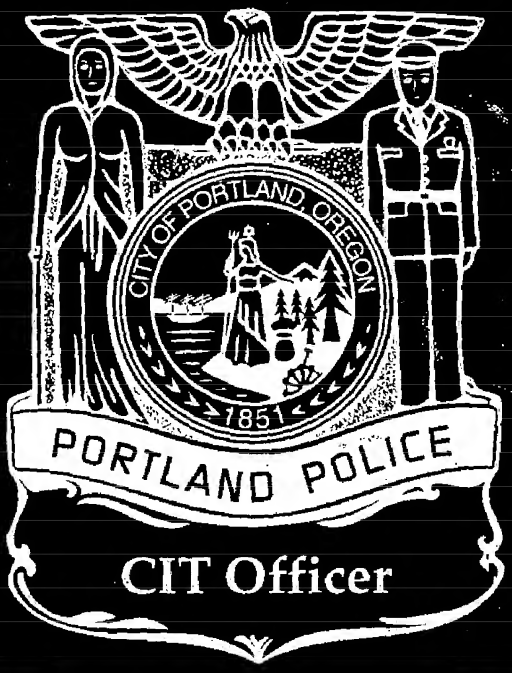
Portland Police Bureau

CRISIS INTERVENTION TEAM

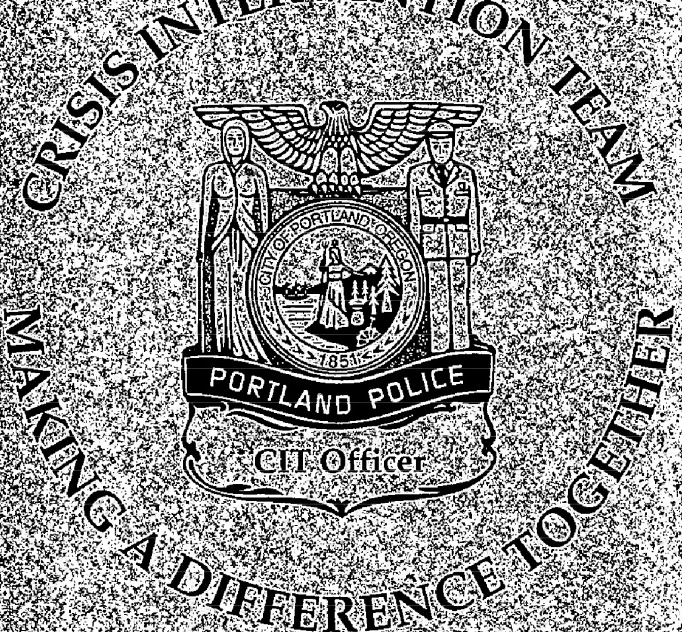


MAKING A DIFFERENCE TOGETHER

CIT Training
May 20th - 24th, 2002
Portland, Oregon

Portland Police Bureau

Crisis Intervention Team



Instruction Manual

CIT Mission Statement:

"The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis."

Crisis Intervention Training

Day:	Monday Nov. 26th	Tuesday Nov. 27th	Wednesday Nov. 28th	Thursday Nov. 29th	Friday Nov. 30th
Location:	*Portland Adv./ Amp. D*	*Portland Adv./ Amp. C*	*Off Site*	*Portland Adv./ EdCenter. A*	*Portland Adv./ EdCenter. A*
0800-0900	Class Introduction	Review/ Civil Commitment,	Site Visits	Review/ MR/DD	Culture Panel
0900-1000	Childhood Disorders	P.S.R.B., and Consumer Rights	Site Visits	MR/DD	Scenarios
1000-1100	Overview of Mental Illness	Overview of M.H. System	Site Visits	Mental Status Exam	Scenarios
1100-1200	Overview of Mental Illness	Aging Services	Site Visits	BPLS/Violence Curve	Scenarios
1200-1300	Lunch	Lunch	Lunch	Lunch	Lunch-Move to SE Precinct
1300-1400	Overview of Mental Illness	Personality Disorders	Site Visits	Suicide Intervention	Officer Scenarios
1400-1500	"Voices"	Personality Disorders	Site Visits	Crisis Intervention	Officer Scenarios
1500-1600	Modeling Mental Illness	P.T.S.D.	Site Visits	Crisis Intervention	Officer Scenarios
1600-1700	Family and Consumer Panel	Alcohol & Drugs	Site Visits	Crisis Intervention	Graduation

Training will take place at Portland Adventist Hospital in the listed rooms. Except for Friday afternoon, when we will move to Southeast Precinct's Community Room to complete the training.

November 28, 2001:
Site Visitation Schedule

Time	Group A	Group B	Group C	Group D
0800-0900	Rennisance/ Clinic	Rennisance/Clinic	Ryles Center	Ryles Center
0920-1020	Ryles Center	Ryles Center	Rennisance/Clinic	Rennisance/Clinic
1040-1140	Faulkner Place	Port City	Comet Club	Hooper Detox
1140-1300	Lunch & Travel	Lunch & Travel	Lunch & Travel	Lunch & Travel
1300-1400	Port City	Royal Palm Hotel	Hooper Detox	New Mezz Connection
1420-1520	Bridgeview	Rainbow Adult Living	MCDC	MCDC
1540-1700	MCDC	MCDC	Bridgeview	Faulkner Place

Bridgeview: 707 NW Everett. Contact: Erin Fisher (Ph. 222-4906)

Comet Club: 5507 N. Lombard. Contact: Jessica Turner (Ph. 285-9871 ext. 315)

Faulkner Place: 13317 SE Powell Contact: Alan Wood (Ph. 760-9606)

Hooper Memorial Detox: 20 NE MLK Jr. Blvd. Contact: Jeanne Rivers (Ph. 238-2067)

MCDC: Meet in the Main Lobby, Contact: Kathy McCullough (Ph. 988-5230)

New Mezz Connection: 1122 SW Stark. (Enter through metal gate, then double glass doors, then into Day Treatment Center) Contact: Lorraine Vitkauskas (Ph. 552-5125)

Port City: 1847 E. Burnside. Contact: Brenda or Judy (Ph. 236-9515)

Rainbow Adult Living: 3701 SE Belmont. Contact: Greg Ruff (Ph. 231-1608)

Rennisance / Network Walk-in Clinic:

Royal Palm Hotel: 310 NW Flanders. Contact: Robin Hochtritt (Ph. 827-3949)

Ryles Center: 3339 SE Division. Contact: Kay Endres (Ph. 238-1477)

Section 1: Mental Illness

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

    feel - most commonly of bugs crawling on the body
    smell - often of gas associated with death plots
    taste - usually of poisons in food
    hearing - voices telling the person to do something
    sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind
  usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

B Basic P Psychiatric L Life S Support

Portland Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

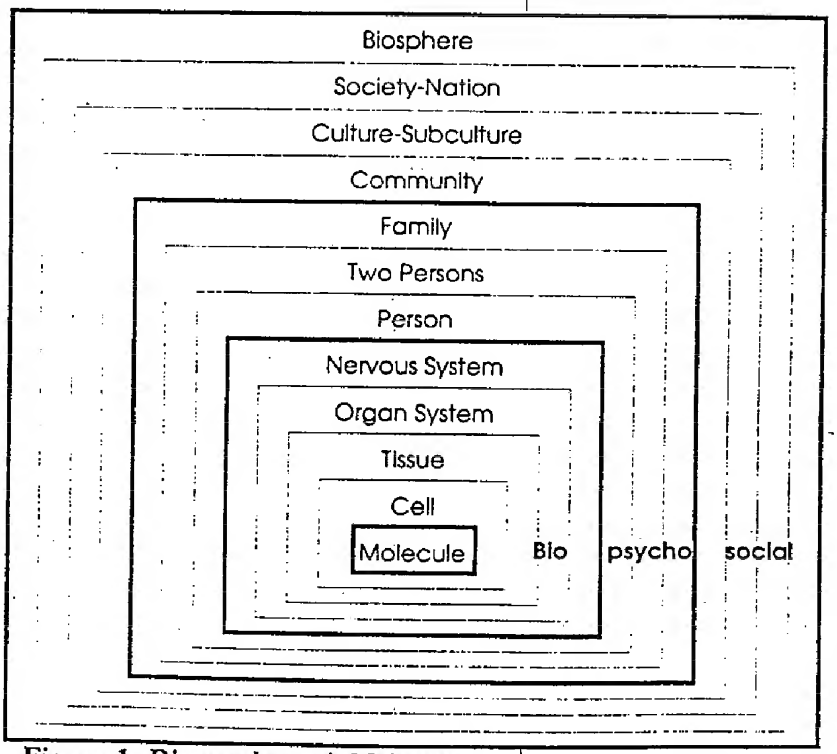


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

Top priority must be the professional's immediate physical safety.

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?
Urgency: How fast must a response occur to be effective?
Remediability: How much difference will any response make?
Sequence: Does one step require a prior step?
Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

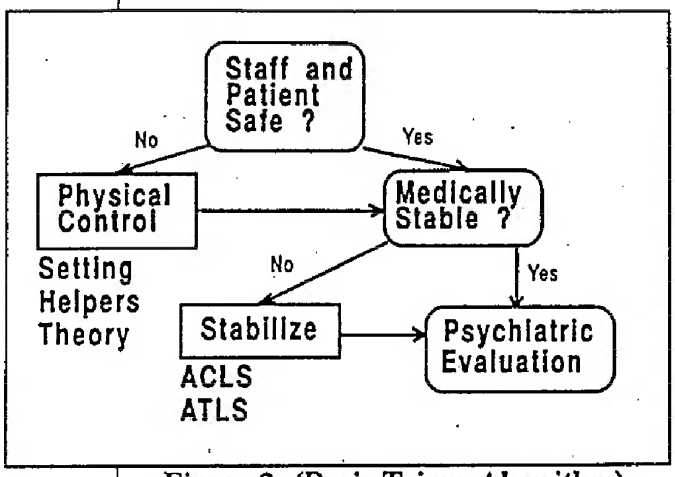


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:
To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:
Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

4.1.2 Personnel:
Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

Estimating the patient's control and deciding when the professional must assume control is key.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("If...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid) (Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

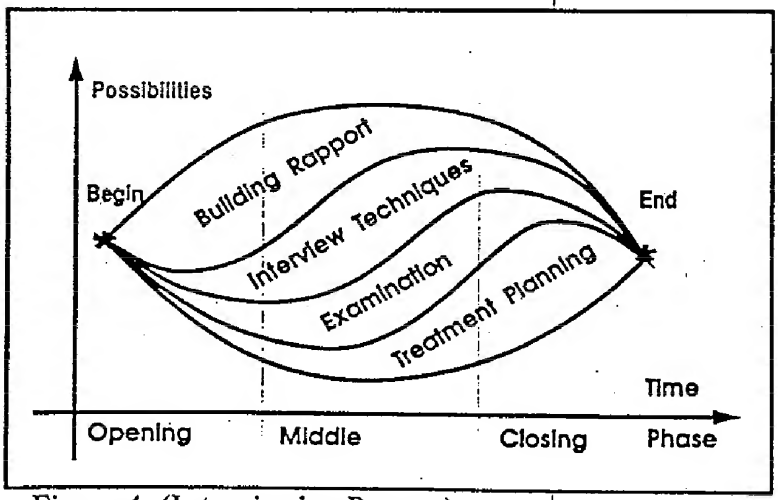


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

Knowing the relative importance of historical information can lead the interview.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:

The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:

The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

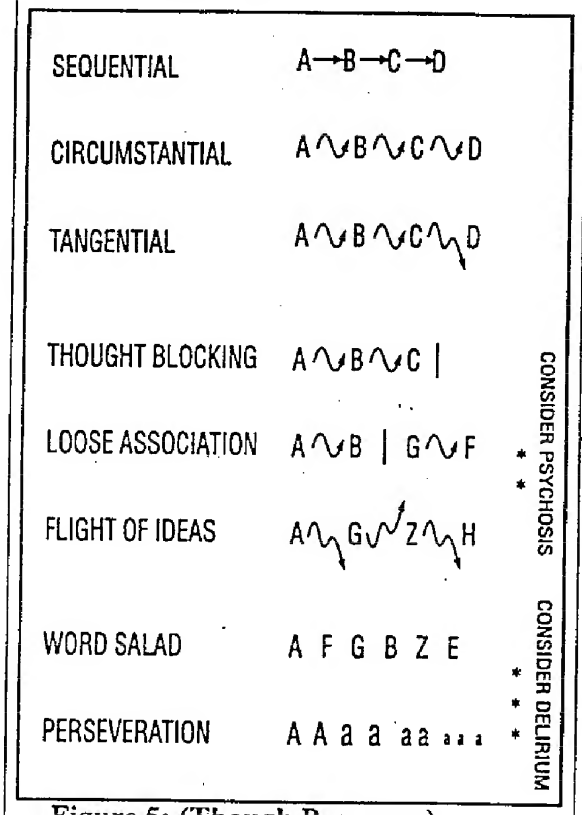


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a non-bizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes: Stamped envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

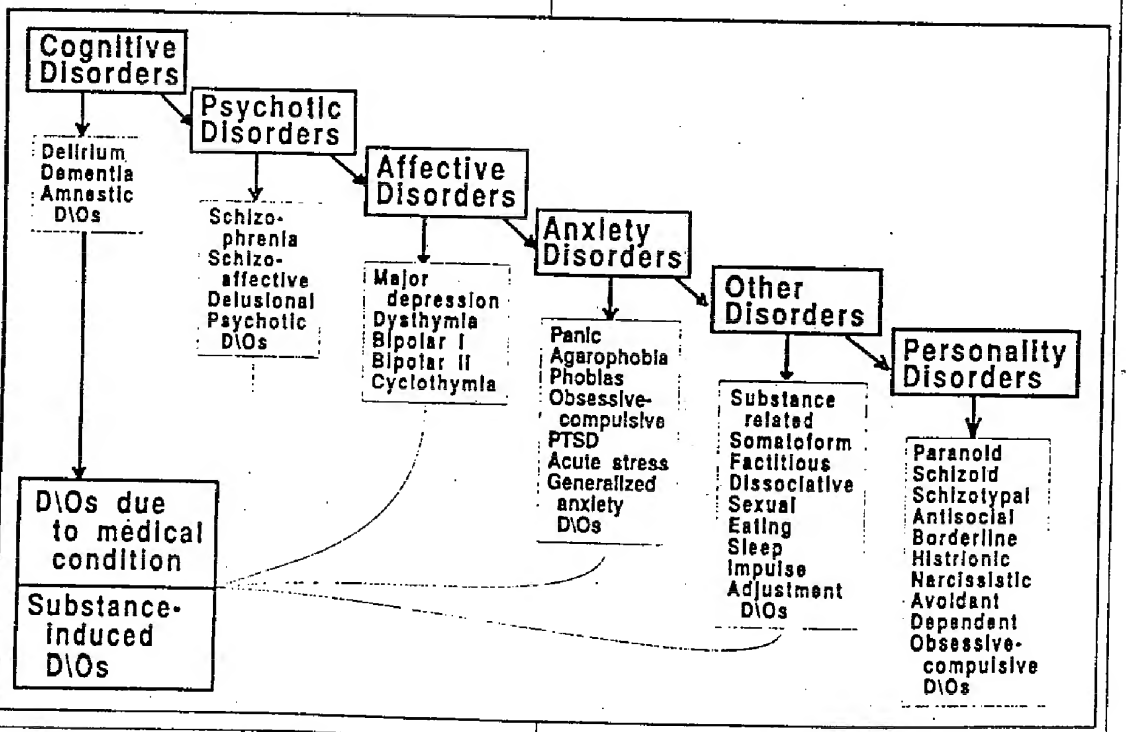
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

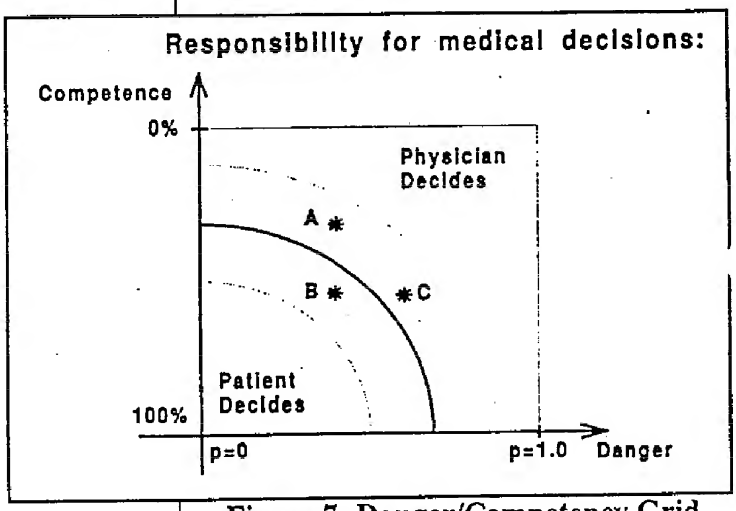


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

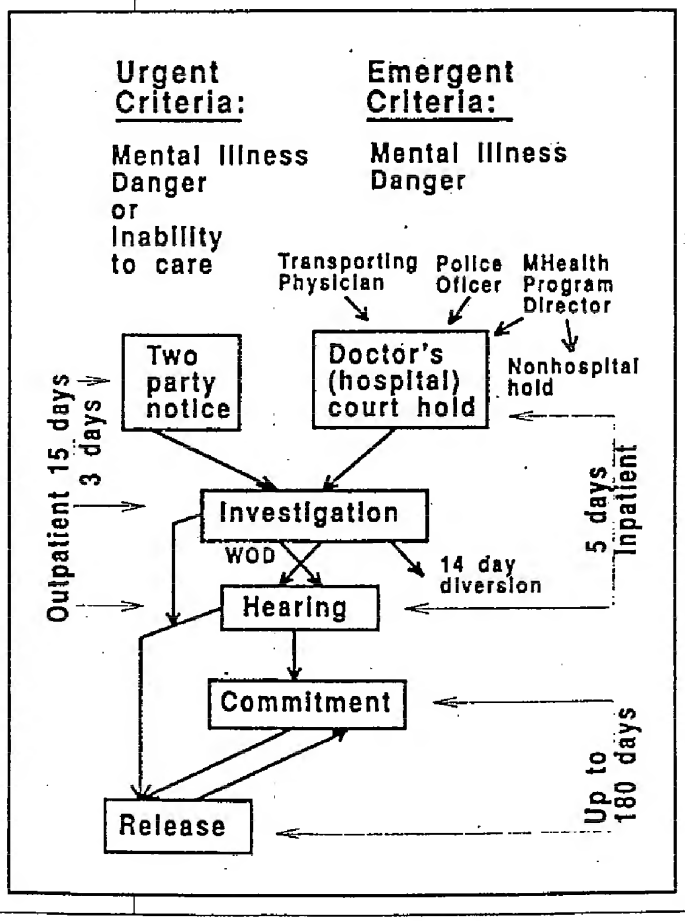


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

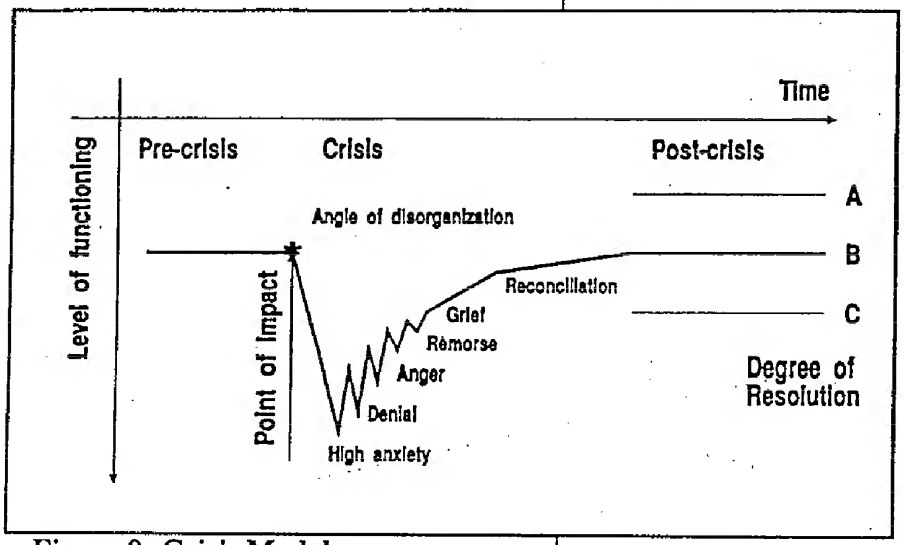


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

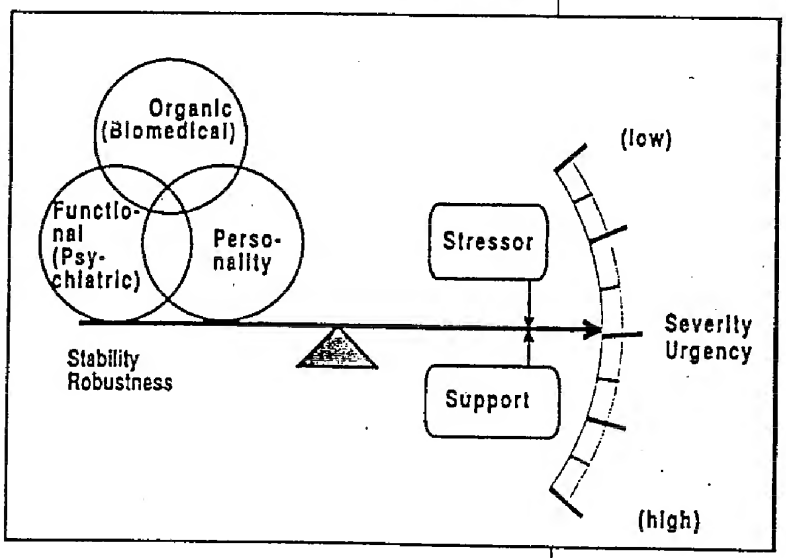


Figure 10: Crisis Intervention

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires, yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

Please address all inquiries to:
Rupert Goetz, MD
Oregon Health Sciences University
3181 SW Sam Jackson Park Road
Portland, OR 97201

Version: 7-10-95

11. Bibliography

1. Engel GL: The Need for a New Medical Model: A Challenge for Biomedicine. Science 196:129-137, 1977

2. Schurman RA, Kramer PD, Mitchell JB: The Hidden Mental Health Network: Treatment of Mental Illness by Nonpsychiatrist Physicians. Archives of General Psychiatry 42:89-94, 1985

3.American Heart Association: Textbook of Advanced Cardiac Life Support. American Heart Association, 1987

4. Pokorny A: Prediction of Suicide in Psychiatric Patients. Archives of General Psychiatry 40:249-257, 1983

5. Lidz W, Mulvey E, Gardner W: The Accuracy of Predictions of Violence to Others. Journal of the American Medical Association 269:1007-1011, 1993

6. Wickersty, A.: Personal Communication.

7. Othmer E, Othmer SC: The Clinical Interview Using DSM III R. The American Psychiatric Press, 1989, p 13

8. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed. American Psychiatric Association, Washington DC, 1994

9. Dubin WR, Weiss KJ, Dorn JM: Pharmacotherapy of Psychiatric Emergencies. Journal of Clinical Psychopharmacology 6:216-228, 1986

10. Gutheil, TG, Bursztajn, H, Brodsky A: The Multidimensional Assessment of Dangerousness: Confidence Assessment in Patient Care and Liability Prevention. Bulletin of the American Academy of Psychiatry and the Law, 14:123-129, 1986

NOTES

NOTES

NOTES

CRISIS INTERVENTION TEAM TRAINING
MAY 15, 2000

OVERVIEW OF MENTAL ILLNESS

WHAT IS MENTAL ILLNESS?

A biologically based brain disease characterized by

- perceptual disturbance
- mood lability
- lack of motivation
- and in extreme cases, suicidality.

Mental Illness can impact all areas of a person's functioning including

- **Social** — difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
- **Occupational** — difficulty acquiring and/or maintaining employment
- **Interpersonal** — difficulty maintaining relationships with friends, co-workers, partners, spouses, parents, children

Symptoms of mental illness may be exacerbated by environmental stressors including

- Poverty
- Homelessness
- Difficulty accessing medical care
- Poor nutrition
- Drug and alcohol addiction

Symptoms of mental illness may be alleviated by medicine and social supports including

Help in --

- keeping up an apartment
- shopping for food
- budgeting money
- attending to hygiene
- planning social activities
- making friends and maintaining relationships
- Easy access to mental health care that is affordable and tailored to the needs of the person

WHAT MENTAL ILLNESS IS NOT

- Mental illness is not a character flaw.
- Mental illness is not a guarantee that the person will be violent.
- Mental illness is not anyone's fault.
- Having a mental illness does not mean there is no hope.

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Thought Disorders

- Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
- Talk to self
- disorganized thoughts
- Paranoia, delusions, or bizarre thoughts
- Minimal display of emotion
- Poor hygiene/malodorous
- May wear multiple layers of clothing or inappropriate clothes for the weather
- May have multiple bags filled with what might appear to be garbage

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Mania:

- Expansive irritable mood
- Decreased need for sleep
- Heightened self-esteem
- Grandiose ideas
- Pressured speech /inability to interrupt them
- Distractibility
- Poor impulse control (e.g. buying sprees, sexual indiscretions)
- Possible break with reality, i.e. psychosis

WHAT A PERSON WITH MENTAL ILLENSS MIGHT EXPERIENCE

People with major depressive disorder often do not act in a bizarre manner

Common symptoms of depression include:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in all or most activities of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Feelings of worthlessness
- Recurrent thoughts of death or thoughts of suicide

It is a myth that depression is a normal part of the aging process. It is important to remember that depression is an illness which can be successfully treated.

IF YOU HAVE TO TAKE THE PERSON INTO CUSTODY ON A HOLD SOMETIMES IT IS HELPFUL TO:

- Ask the person if they have ever been in handcuffs before
- Tell the person that you came to help them, not to hurt them
- Tell them they are not under arrest or in trouble
- Tell them you know that they are not a bad person
- Tell them your boss says you have to put them in handcuffs, it is the rule, it's nothing personal

ORGANIC AND PSYCHOTIC MENTAL ILLNESS

WHAT IS PSYCHOSIS

Psychosis is defined by a complex of symptoms that include:

Delusions (false beliefs in something that is so at odds with the prevailing societal consensus as to be recognized as ranging from the improbable to the bizarre).

Hallucinations (the experience of sensation in the absence of external stimulation, most commonly auditory, but in drug induced states or other organic states can include visual, olfactory, gustatory, and tactile sensations. That is hearing, seeing, smelling, tasting and feeling.)

Incoherence (unintelligible speech or speech which may make sense but conveys little or no information even though the person may talk a lot).

Loosening of Associations (the lack of connection in a person's flow of thought so that ideas seem to generate other ideas which have no logic to their sequence).

Catatonia (marked excitement or profound stupor and muteness to the degree that a person is at risk for life threatening exhaustion or is unable to carry out basic functions such as food seeking and feeding).

Gross Disorganization (marked difficulty in organizing behavior so that a person may be disoriented to time, place and identity, may be unable to respond to others or unable to respond in an understandable manner).

There is a range of conditions which may produce psychotic behavior. This may vary from; a brief reactive psychosis which is a response to excessively traumatic stress (for example: combat); to substance induced psychotic reactions; to psychosis due to a progressive brain deterioration such as in a dementia like Alzheimer's; and psychosis due to a chronic mental disorder such as schizophrenia or severe mood disorder as in psychotic depression or in psychotic mania.

The neurobiological basis of psychosis appears to stem largely, but not exclusively, from the disruption of dopamine transporting systems in the brain. This can be due to endogenous (internal) causes such as mental illness or dementia but also may be due to exogenous (external) causes such as head trauma or exposure to certain chemicals.

For our purposes, we are **concerned with those chemicals which have reinforcing properties in the brain and are likely to be abused.** Repeated use of

substances such as **alcohol, speed, crank, coke, crack, hallucinogenics, designer drugs**, increases the risk of developing a drug induced psychosis or "triggering" an existing condition such as schizophrenia or severe mood disorder. This appears to be due to the dopaminergic (dopamine stimulating) action of these substances in the brain.

The most common psychiatric symptom resulting from repeated or heavy use of any of the amphetamine type drugs is delusional thinking. Paranoid delusions of persecution and other bizarre or unusual explanations of events are frequently seen. Accompanying this paranoia can be agitation, anxiety and aggressive behavior so that persons in a drug induced psychotic state have much more potential for violent acts including homicide and suicide.

Think of the brain as an elaborate circuit board with very complex electrical interconnections which form our self-awareness, our experiences, our thoughts, our sensations, our perceptions, our memories. If you pour water on a circuit board it shorts out due to the water acting as an electrical conductor between parts of the circuits that weren't meant to be connected. Drugs act the same way in the brain except instead of water being the disruptive electrical conductor, they act on the neurotransmitters which conduct electrical activity. If the brain is no longer able to carry out established interconnected patterns of electrical activity and different pathways become involved, what the brain experiences is psychosis. What others see is that the psychotic person does not make sense and is responding to stimulation that is internal and not shared or understood by others.

Usually, if an individual abstains from drugs, **the psychotic symptoms will go away with time.** The symptoms generally go away within hours to days, although they can last several months and, for some unfortunate individuals, they may become permanent. **The population at highest risk for permanent damage is the one with an existing mental illness or mood disorder or, has a predisposition to develop a mental illness or mood disorder.**

At this time, the single most effective known treatment for psychotic disorders is the use of anti-psychotic medications. These are believed to have a stabilizing effect on the dopamine balance in the brain. These medications, however, are not 100% effective and they carry some risk of side effects. About 25% of people with psychotic symptoms do not obtain a favorable response to existing anti-psychotic medications. Hallucinations, confusion and disorganization generally respond to anti-psychotic medications but delusional thinking tends to be less responsive. Ideally however, treatment should combine medications with social therapies to be the most effective. There are some individuals who can recover without the use of medications but they are in a minority.

Denial is a major element making for great difficulty in the treatment of psychotic states that are either drug induced or due to chronic mental disorders. Frequently, the person experiencing the psychotic effects of drugs or of mental illness believes that what his senses are telling him is an accurate reflection of external reality. This is what we all believe and rely on to navigate through the world. When someone tells a psychotic individual that what they are experiencing is not "real", it is very difficult to make a convincing argument. What is going on in that person's brain is their reality so they must deny any challenges to that reality and refuse to accept any offers of treatment and refuse to believe that they might need treatment.

A common outcome is that a psychotic person comes to the attention of the police. A quick determination is made if the psychotic person poses some danger to themselves or others and is not willing to obtain voluntary treatment. The individual is transported to an emergency psychiatric facility where they can be detained against their will, for up to five court days. During this time an investigator must make a determination as to whether or not the person is to go to Civil Court before a judge and psychiatric examiners for an involuntary commitment hearing. The Civil Court has the authority to place the person under the care and custody of the Mental Health Division for a period not to exceed 180 days if they find the person continues to be mentally ill, a danger to self or others and is unable or unwilling to accept voluntary care. While under commitment and within the guidelines of the law, a person can be administered psychiatric medications against their will.

Go back now to the earlier statement that most drug induced psychotic states clear in a few hours to a few days. If a person in this condition is taken to a psychiatric emergency holding facility they are likely to be released without a commitment hearing. But, for the person whose symptoms persist, they stand a good chance of being committed and placed in a psychiatric hospital.

If a crime was committed at the time the person was picked up by the police, the person may have a detainer placed on them while in the hospital and then be transferred to jail once their symptoms have cleared. If the crime is serious enough, a mentally ill offender may go straight to jail and then quickly to court for a judge's order to be sent to Oregon State Hospital Forensic Unit for evaluation or treatment. Petty crimes committed while the person is psychotic are often dismissed if the court feels that the individual is getting the treatment they need. Repeat offenders are not as likely to be looked upon with such leniency particularly if they persist in denying they need treatment or do not follow through with treatment.

Mental illness is not a state of bliss. It can be a world filled with fear and confusion. Whether psychosis is drug induced or not doesn't make any

difference to your brain but **the choice to use or not use drugs of abuse will make a major difference in how your brain is going to function.**

Organic Disorders

a. Definition
   1. A class of conditions caused directly by abnormalities of brain structure or by alterations of brain neurochemistry or neurophysiology (e.g., delirium, dementia, amnesic syndrome, organic hallucinosis, organic delusional syndrome, organic mood syndrome, organic personality syndrome, etc.)

b. General symptoms
   1. Confusion, memory disturbance, disjointed speech, slow mentation, and substance abuse

   2. Physical signs
      a. Breath smells
      b. Blood shot eyes
      c. Runny nose
      d. Needle tracks
      e. Slurred speech
      f. Unsteady on feet
      g. Bizarre behavior and speech

   3. Head Trauma
      a. Permanent
      b. Slow mentation
      c. Impulsive
      d. Seizures
      e. Personality change

   4. Stroke
      a. Usually older person
      b. Paralysis
      c. Difficulty speaking

5. Dementia
    a. Older person
    b. Confused, especially about personal information
    c. Combative
    d. Often in a nursing home or has a specific care provider

6. Medical Causes
    a. Diabetic not taking insulin
    b. Drug overdose
    c. Delirium – fluctuating levels of consciousness
    d. Past seizures
    e. Off seizure medications
    f. Physical illness (sweating, nausea, vomiting)

Psychotic Disorders

a. Definition
   1. A disturbance of perception and thought process is a broad description of this category. The psychotic symptoms represent manifestations of disturbances in the flow, processing, and interpretation of information in the central nervous system. These symptoms can be mild to severe. (Mental Health : A Report of the Surgeon General)
   2. Hallucinations are the most common group of symptoms that result from this disordered processing and interpretation of sensory information. An example is the frequently described hallucination of hearing voices.
   3. Hallucinations may include:
      a. auditory
      b. smell
      c. feel
      d. visual
      e. physical
   4. Delusions are a more complex group of symptoms resulting from this disordered interpretation of information. A delusion is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others are trying to harm him. Any attempts to persuade the person that these beliefs are unfounded typically fail and may further entrench the delusional belief.
   5. Psychotic thought processes are characteristically loose, disorganized, illogical, or bizarre. These thought processes frequently produce bizarre observable patters of behavior that is also disorganized and bizarre.

Schizophrenia

a. The cause of schizophrenia has not yet been determined although research points to the interaction of genetic endowment and major environmental upheaval during the development of the brain. (Mental Health: A Report of the Surgeon General)
b. Part of the psychotic disorders schizophrenia frequently have marked disturbances in logical thought process.
c. Symptoms can include:
    1. Hallucinations
    2. Delusions
    3. Disorganized thoughts and behaviors
    4. Loose or illogical thoughts
    5. Agitation
    6. Flat or blunted affect
    7. Concrete thoughts
    8. Anhedonia (inability to experience pleasure
    9. Poor motivation, spontaneity, and initiative

MOOD DISORDERS

Mood Disorders

a. A group of clinical conditions characterized by a disturbance of mood, loss of that sense of control, and a subjective experience of great distress. This disturbance of mood can be manifested by either stained feeling or sustained elevation of mood. As with psychosis the disturbance of the mood occurs in a variety of patterns associated with different mental illnesses. (Mental Health: A Report of the Surgeon General)

Bipolar or Manic Depressive

a. Symptoms include mood swings from the lows of depression to the highs of mania. These episodes alternate and in some cases can be predicted. Severely affected people have a "rapid cycling" bipolar illness, in which the mood swings occur almost continuously.
b. Depression: symptoms include melancholy, sad, miserable most of the time. Loss of interest in life and pleasures. There can be a decreased energy level, fatigue, fits of weeping or constantly feeling like crying, and an unusually high degree of irritability. There is also a on going thoughts of suicide in severe cases.
c. Manic symptoms include a feeling of power, increased energy, seductive, elated, euphoric. Other symptoms include talks too fast, loud and without stopping. Thoughts race from one idea to the next in rapid succession without much logic. Stop eating, sleeping which in turn can change mood to irritability, anger, paranoia.

Major Depression

a. Ongoing feelings of melancholy, sad and miserable most of the time with loss of interest in life and pleasures. These episodes can also include decreased energy, fatigue, fits of weeping or constantly feeling like crying. Symptoms may

vary with individual, but are long lasting and affect the quality of life for the person.

b. The though process is constantly negative with hopelessness dominating present and future. Anxiety, dread can increased the individual's inability to function. Difficulty in concentration and making decisions; experience feelings of guilt, self-loathing, or worthlessness. Preoccupies with death and suicidal thoughts or attempts.
c. Physically individuals may experience disruptions in normal eating and sleeping patterns. Some are unable to sleep and others may sleep more hours than usual.
d. Behavior includes inability to get work done and difficulty in reading or studying. There is a great difficulty in accomplishing simply tasks such as washing, dressing, and eating. There may also be some restlessness and agitation. The characteristics include slowed thoughts, movements, and speech; walk stooped and shuffling gait

NOTES

NOTES

POST TRAUMATIC

STRESS DISORDER

Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

Additional Stressors of War

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a roc jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceilir. just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

•

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

Trauma Recovery and Counseling Center
5999 Stevenson Avenue, Suite 404
Alexandria, Virginia 22304
David P. Niles, EdD., CCMHC (703) 823-6102

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3976

Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker, RN

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3976

Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Permission is hereby granted to reproduce this material in any form and quantity necessary, for any use except for resale.

Sincerely,

Joe Parker, RN

COR-168 Rev. 2/93

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

DEPARTMENT OF HUMAN SERVICES
MULTNOMAH COUNTY
HEALTH DIVISION
CORRECTIONS HEALTH
COR-168 - 5/90

We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written history of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what is remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control these symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. They do not provide a high, are not addicting, are legal, and are much safer than street drugs.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb hurts. Being cut off from good things, including people, makes you sad.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really listen. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people may talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from hearing about what you had to live, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that learn, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be internal, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

- feeling nothir
- loss of not... interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

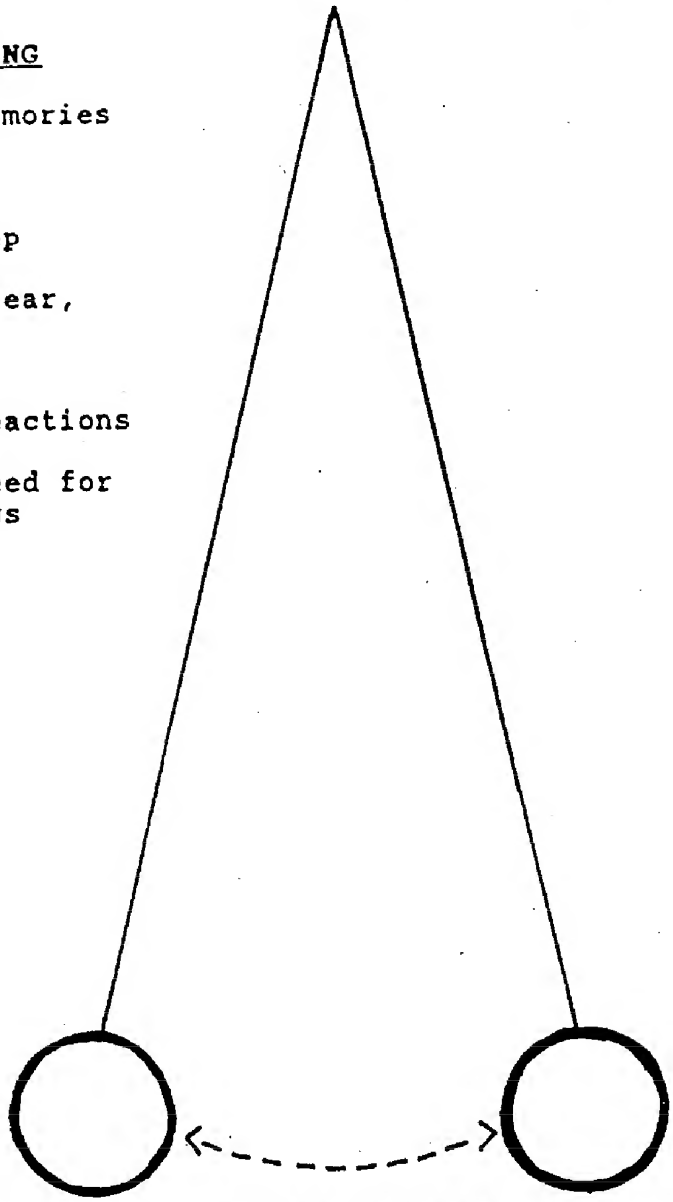
TOO AGITATED

TO WORK ON

PROBLEMS.

TOO MUCH

ENERGY.



UNABLE TO HOPE

FOR THINGS TO

GET BETTER.

NOT ENOUGH

ENERGY.

"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period

- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:

Lifetime Prevalence

	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

Social:

- Means to behave like non-mentally ill peers
- Opportunities to be around others w/o high social demands
- Creates a sense of belonging to a social group

Self-Medication:

- Anxiety Reduction
- Improved ability to concentrate
- Improved energy level
- Increased sense of ability to function and well being
- Improved mood

Addiction:

- Physical and psychological dependence
- Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.

- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.

- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.

- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.

- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.

- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.

- Routes of administration can be oral, IV, intranasal, or through inhalation.

- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics.* They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks.* They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.

- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranoia.

- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.

- Acute mood changes, including euphoria, depression or irritability.

- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'

- Homelessness and itinerancy (frequent moving from place to place).

- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.

- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.

- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.

- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP	[redacted]	Sedative	[redacted]	Cocaine	Sedative Withdrawal
Cocaine	[redacted]	Stimulants	[redacted]	PCP	PCP Intoxication
Meth	[redacted]	[redacted]	[redacted]	[redacted]	Inhalant Intoxication
Inhalants	[redacted]	[redacted]	[redacted]	[redacted]	Cocaine Intoxication
*LSD	[redacted]	[redacted]	[redacted]	[redacted]	Brain Injuries
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritablity; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritablity; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual); synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

PERSONALITY DISORDERS

Personality Disorders Training
Crisis Intervention training
Portland Police
5/18/00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment.

B. Types:

1. Cluster A Paranoid, Schizoid, Schizotypal,
   - odd or eccentric

2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic,
   - dramatic, emotional or erratic

3. Cluster C: Avoident, Dependent, Obsessive Compulsive
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

III. Management of Behavior

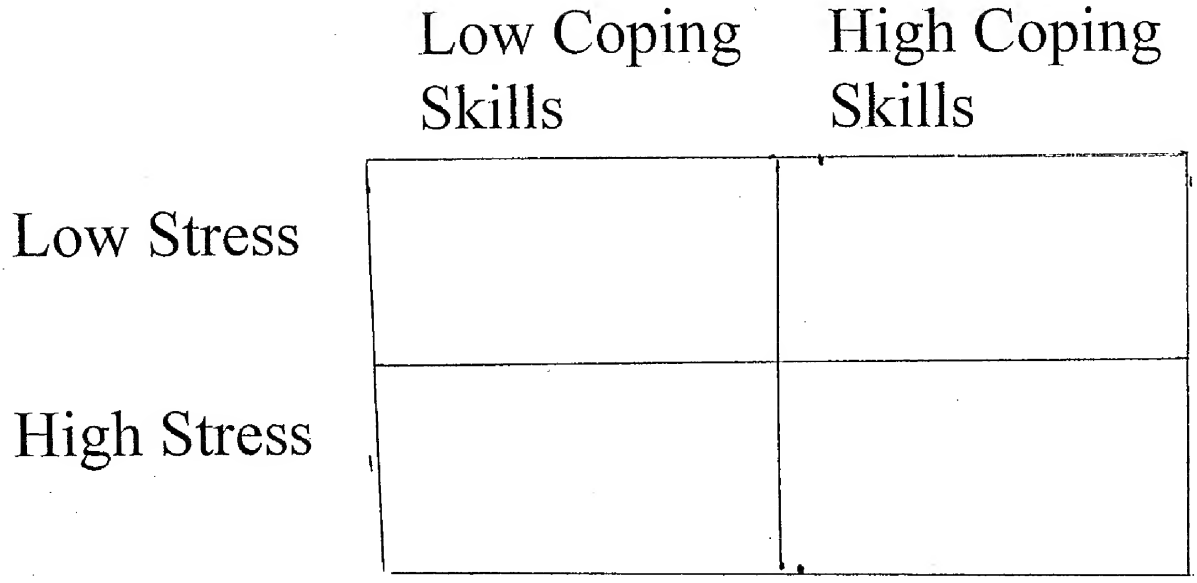
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



CHASSE119079

NOTES

Section 2: Procedures

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

- Appearance

-- How is the individual dressed? Examples of dress which may indicate a mental illness include:

-- Inappropriate for weather (e.g. -- many layers in summer)
-- Inappropriate for context (e.g. -- pajamas in the street)
-- Odd or bizarre clothing
-- Very dirty/foul smelling/tattered clothing

-- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

-- Very dirty/foul smelling clothing
-- Very dirty/foul smelling body
-- Poor dental condition

-- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

-- Responding to internal stimuli (i.e. -- "talking to self")
-- Standing still/staring for prolonged periods (e.g. - catatonia)
-- Disorganized/non-goal directed actions
-- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
-- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
    -- plan
    -- access to enact plan
    -- intent to carry out plan
    -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
    -- memory (short, intermediate, and long term)
    -- concentration/distractibility
    -- abstract thoughts (often mentally ill individuals cannot think abstractly)

•Generalities

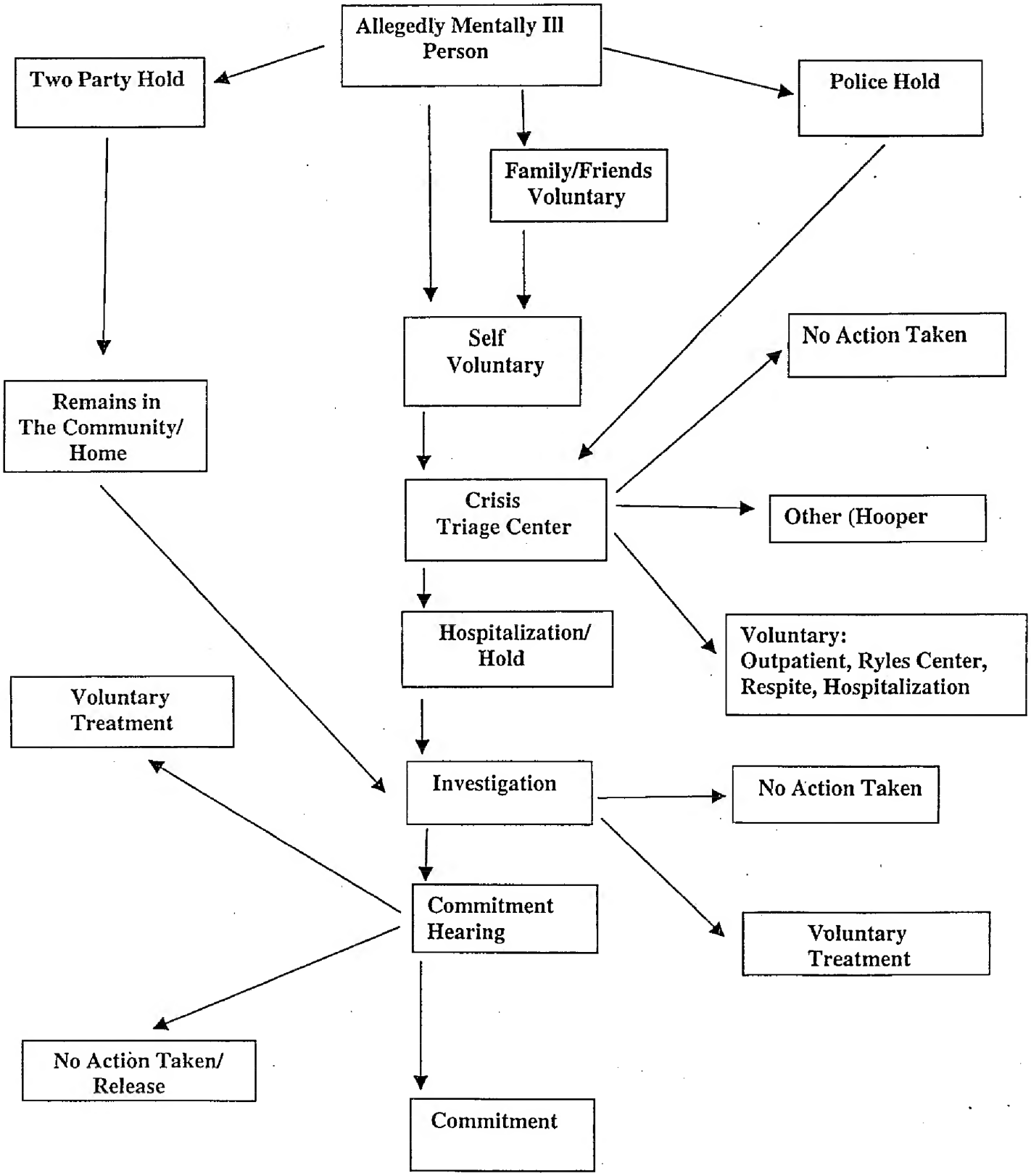
-- If it doesn't feel safe, don't do it!!
-- Mentally ill people are people, and deserve common respect.
-- Listen carefully.
-- Allow the individual to talk at length at least once.
-- Don't be afraid of silences. They often bring out symptoms.
-- Try to be an ally, not an adversary.

	Appearance	Thought Processes	Speech
Psychotic/Schizo-phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

COMMITMENT LAWS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility

AND

b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.

AND

c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

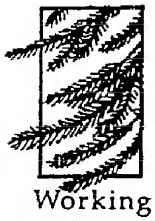
A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

RIGHTS OF THE MENTALLY ILL



OREGON ADVOCACY CENTER
Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

Voice: 503-243-2081 • 1-800-452-1694 • TTY: 1-800-556-5351 • Fax: 503-243-1738
620 S.W. Fifth Avenue • 5th Floor • Portland, Oregon 97204-1428

WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

. . . . .

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders.**

. . . . .

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

. . . . .

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

. . . . .

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

Has a mental disorder and, because of that mental disorder, is:

Dangerous to self or others, or

Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING

A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT

In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

WORKING FOR THE RIGHTS OF INDIVIDUALS WITH DISABILITIES

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

Section 3: Resources

FAMILY AND CONSUMER PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone wants to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes them uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending tiredness that ultimately gets you. You kill yourself because you have to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You have no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
(503)238-0769 • FAX(503)233-2861

January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domiciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

http://www.psych.org/public-infor/MEDS~1.HTM 7-15-99

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting sweating, delayed orgasm

http:noah.cuny.edu/illness/mentalhealth/cornell/medications/antidepsideff.html 7-15-99

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly **rapid tolerance** and are extremely **difficult to withdraw** from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do **not produce tolerance.** The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics

Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The second generation or "atypical" compounds
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The SSRI's (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The MAOs (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The ANTI-MANICS (also referred to as mood stabilizers) are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. Non-addictive and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The "new generation" anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. These **medications can produce dependence and tolerance.** They are less often prescribed now as many of the SSRI anti-depressants and a

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL) MESORIDAZINE (SERENTIL) TRIFLUOPERAZINE (STELAZINE) THIOTHIXENE (NAVANE) RESPERIDONE (RISPERDAL) LOXATANE (LOXAPINE) CHLORPROMAZINE (THORAZINE) HALOPERIDOL (HALDOL) THIORAZINE (MELLARIL) PIMOZIDE (ORAP) MOLIDONE (MOBAN) CHLORPROTHIXENE (TARACTAN) FLUPHENAZINE (PROLIXIN) TRIFLUOPERAZINE (STELAZINE) PERPHENAZINE (TRILAFON) CLOZAPINE (CLOZARIL)	Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention. Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia. Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulusant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE- meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Floricet	NAR	butalbital with aspirin
Florinal	NAR	butalbital with tylenol
Flexoril	MR	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AA	propranolol
Isoptin	AA/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AA	clonazepam
Librium	AA	chlordiazepoxide
Lioresal	MR	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAR	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thiorazine
Miltown	AA	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine
Percocet	NAR	oxycodone with tylenol
Percodan	NAR	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAA	acetominophen with codeine
Tylox	NAA	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Xanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MA
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations,

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

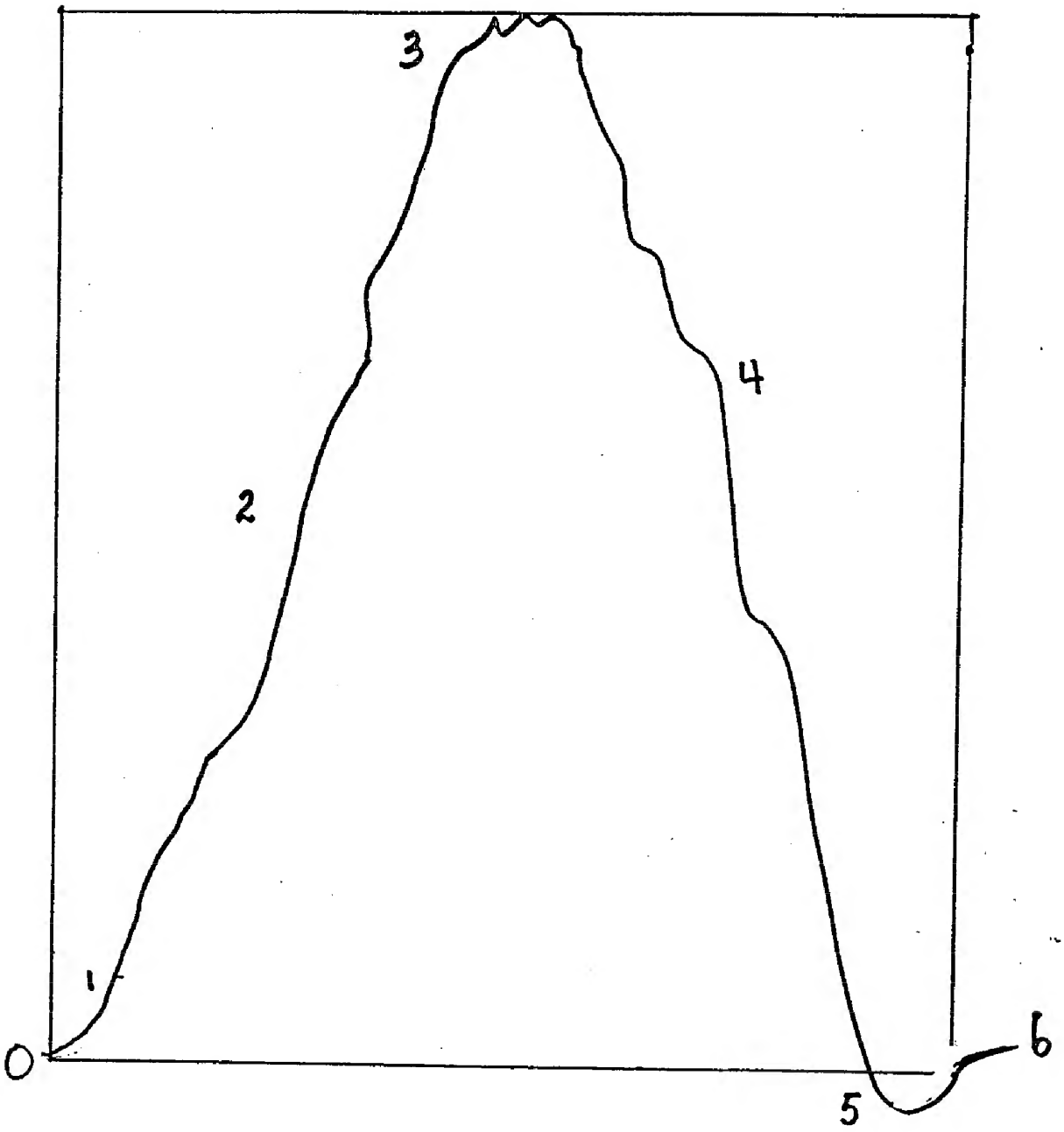
Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

Compiled by Project Respond for the Portland Police Department.

Section 4: Intervention

CRISIS CYCLE

The Crisis Cycle



0 - Normal State
1 - Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post crisis depletion
6. Stabilization

CRISIS CYCLE

0. Normal state.

1. Stimulation

Something has happened to cause the person to become:

Excited or
Active or
Upset or
Physically uncomfortable

Cause can be external or internal or both.

External
Something someone else said or did.
Environment: hot, cold, crowded.

Internal
Physical illness, injury or pain.
Emotional upset
Mental illness: mood disorders, hallucinations.

2. Escalation

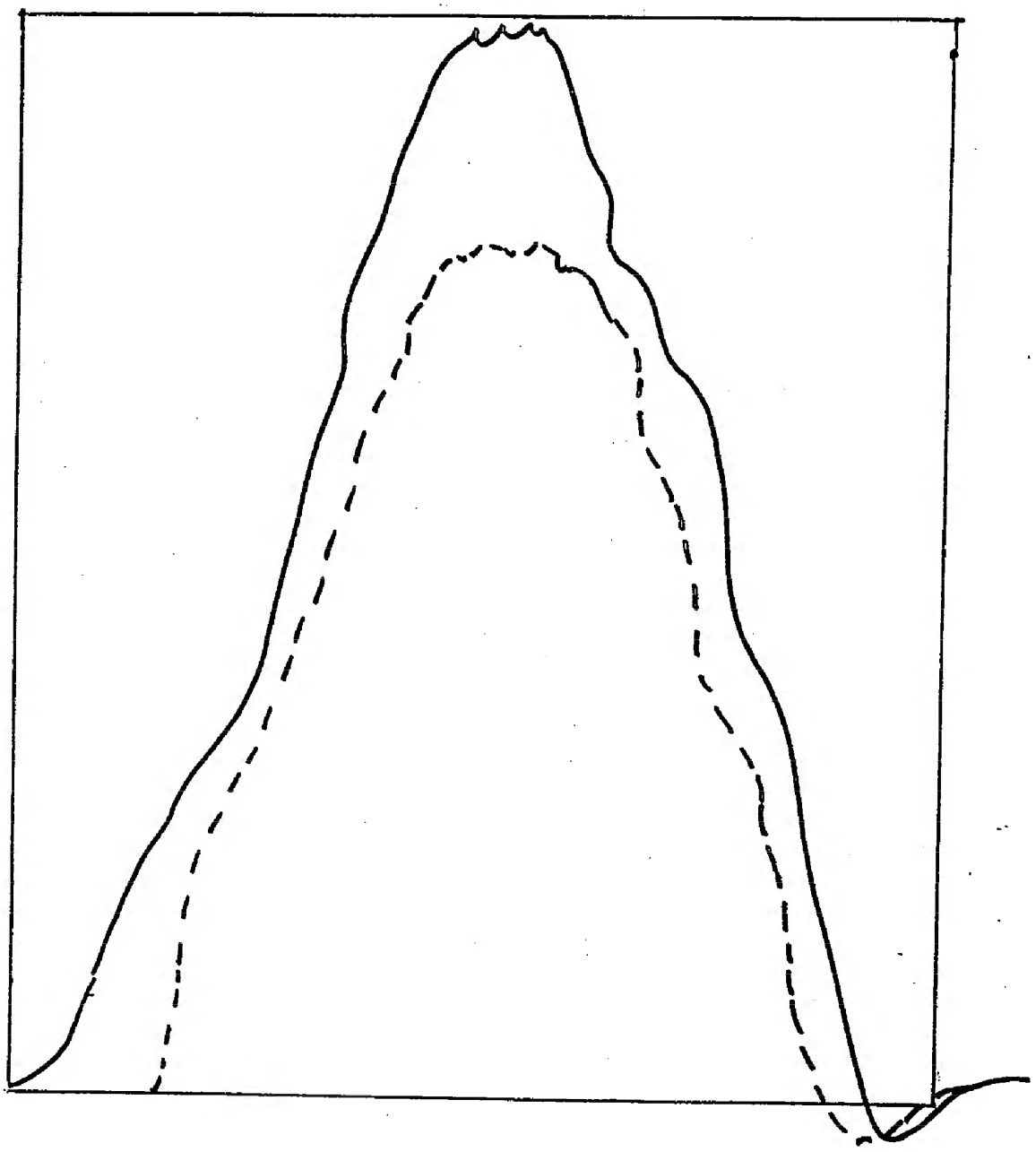
Obvious signs of distress.
Observable physical changes and changes in behavior. (if you don't know the person, it may be hard to know what is a change)

Examples:
Red face
Tense muscles (tight face, clenched fists)
Talking more or louder. (some get quiet/withdrawn)
-Increased activity : Pacing, rocking, etc.

3. Crisis

Out of control.
May scream, yell, curse.
May wave arms or stamp feet.
May assault.

Two crisis cycles juxtaposed



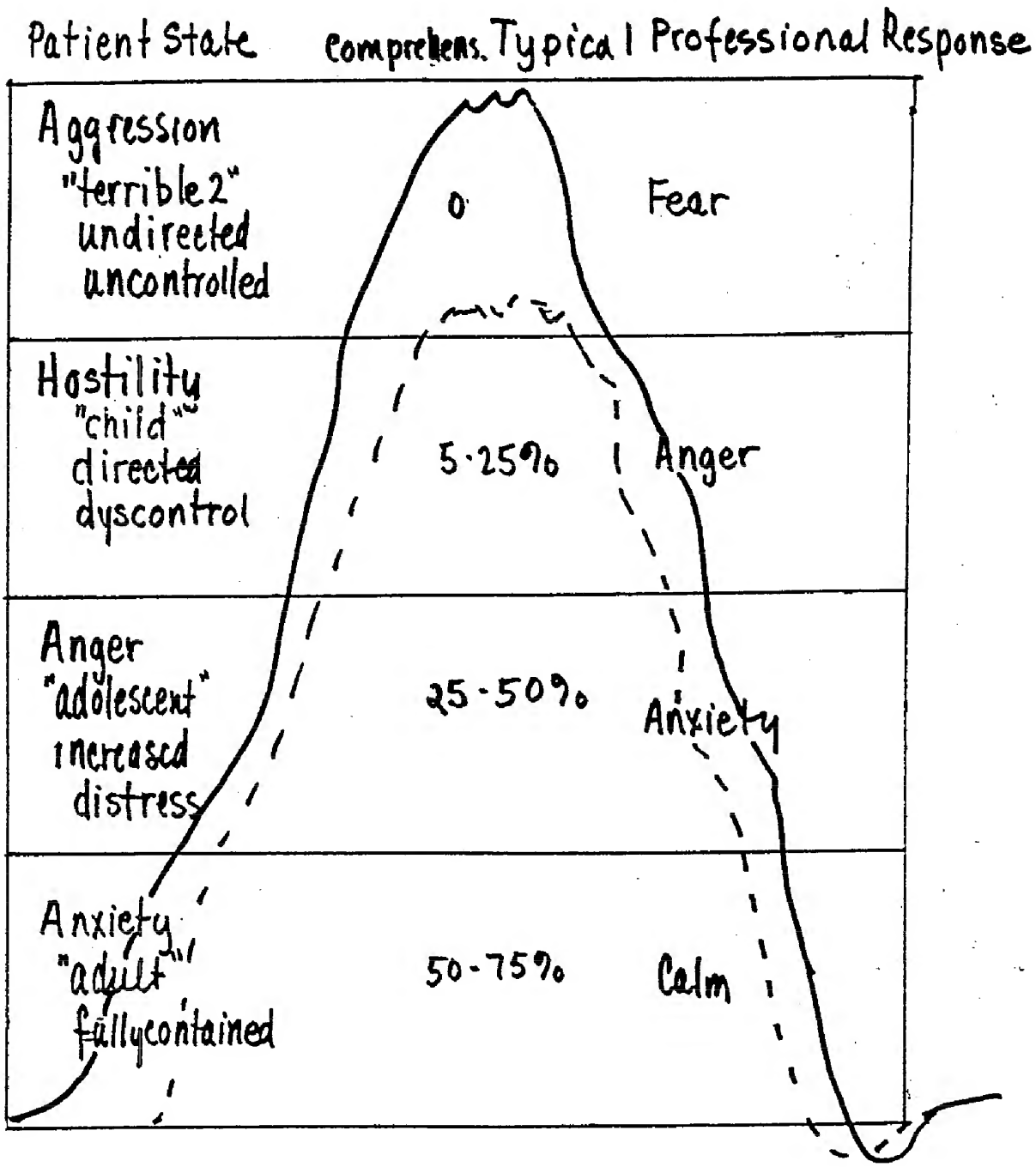
Basic Psychiatric Life Support Model

Patient State	Typical Professional Response
Aggression "terrible 2" undirected uncontrolled	Fear
Hostility "child" directed dyscontrol	Anger
Anger "adolescent" increased distress	Anxiety
Anxiety "adult" fully contained	Calm

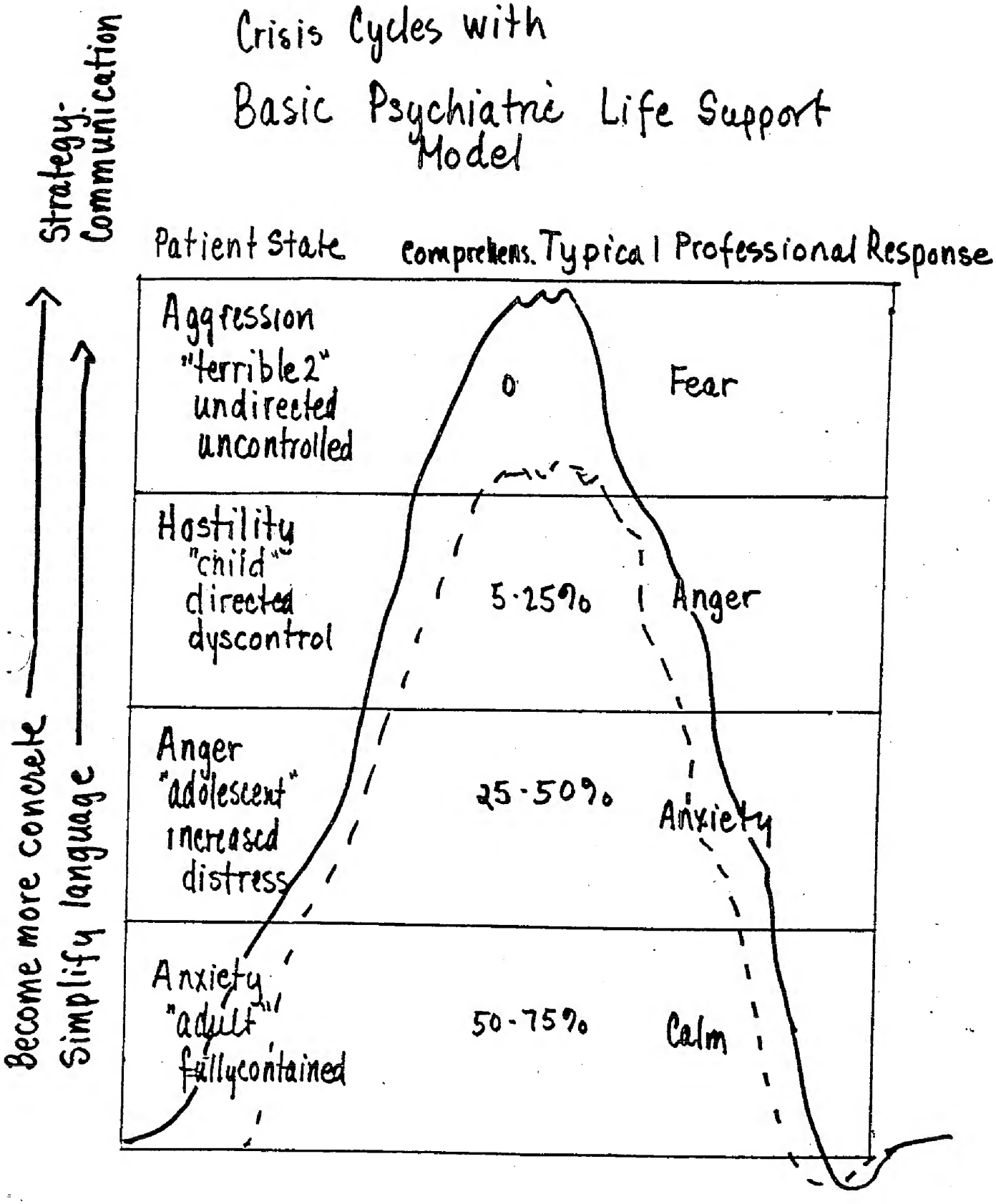
Basic Psychiatric Life Support Model

Patient State	% comprehension
Aggression "terrible 2" undirected uncontrolled	0-5%
Hostility "child" directed dyscontrol	5-25%
Anger "adolescent" increased distress	25-50%
Anxiety "adult" fullycontained	50-75%

Crisis Cycles with Basic Psychiatric Life Support Model



Crisis Cycles with Basic Psychiatric Life Support Model



Course Title: Mental Retardation and Developmental Disabilities: Basics For Police Officers

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 3:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To familiarize officers with characteristics of individuals with developmental disabilities, and how these characteristics may affect officer interactions with individuals.

Performance Objectives:

The officer will demonstrate knowledge of what mental retardation is and distinguish it from mental illness

The officer will be able to identify some characteristics of persons with mental retardation in each of the following areas: communication, interaction, judgement/knowledge; performance abilities.

The officer will be able to list some implications of the above characteristics in managing interactions with victims, suspects, and witnesses.

The officer will demonstrate knowledge of how to identify paid or unpaid helpers of a person with a developmental disability.

Course Outline:

Definitions

1. Mental retardation
2. Developmental disability
3. Distinguishing mental retardation from mental illness
4. Other disabilities that affect cognitive functioning

Some characteristics of individuals with mental retardation

A. Recognition of disability/managing the encounter
B. Wide individual variation in each area.
   C. Communication issues
   D. Interaction issues
   E. Judgement/knowledge isssues
   F. Performance abilities

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fully contained

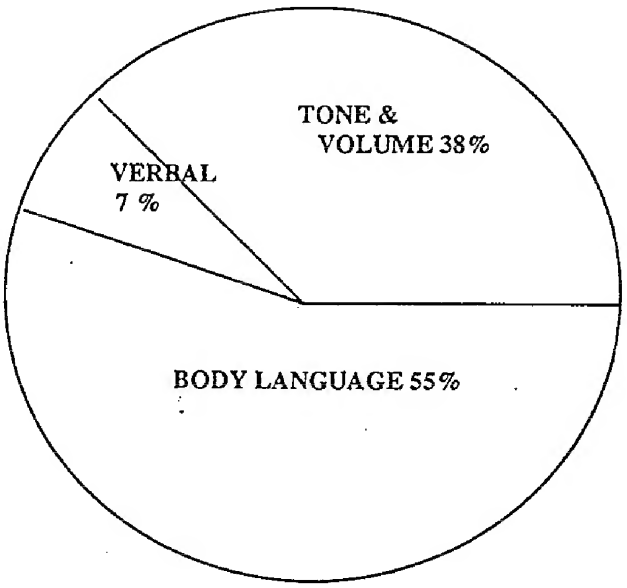
Managing Behavioral Emergencies

As trained crisis intervention specialists, your most likely subjects will be out of control chronically mentally ill persons, angry domestics, suicidal people in public places (bridge jumpers), barricaded individuals, and/or intoxicated persons displaying bizarre behaviors. What do these folks have in common? All will demonstrate some degree of serious impairment in their ability to communicate effectively. This presents a challenge to the police specialist who is attempting to negotiate an alternative to violent behaviors.

One of the few tools that mental health workers have available in dealing with agitated people is the ability to talk down potential assailants. Here are some useful ideas and techniques. The following focus will examine strategies in which you might maximize your ability to deal with agitated people. None of the material in itself is new. The objective for this presentation is to examine principles of applying effective communication techniques to de-escalate agitated persons when possible.

COMMUNICATION

When individuals are highly stressed, non-verbal communication becomes dominant.

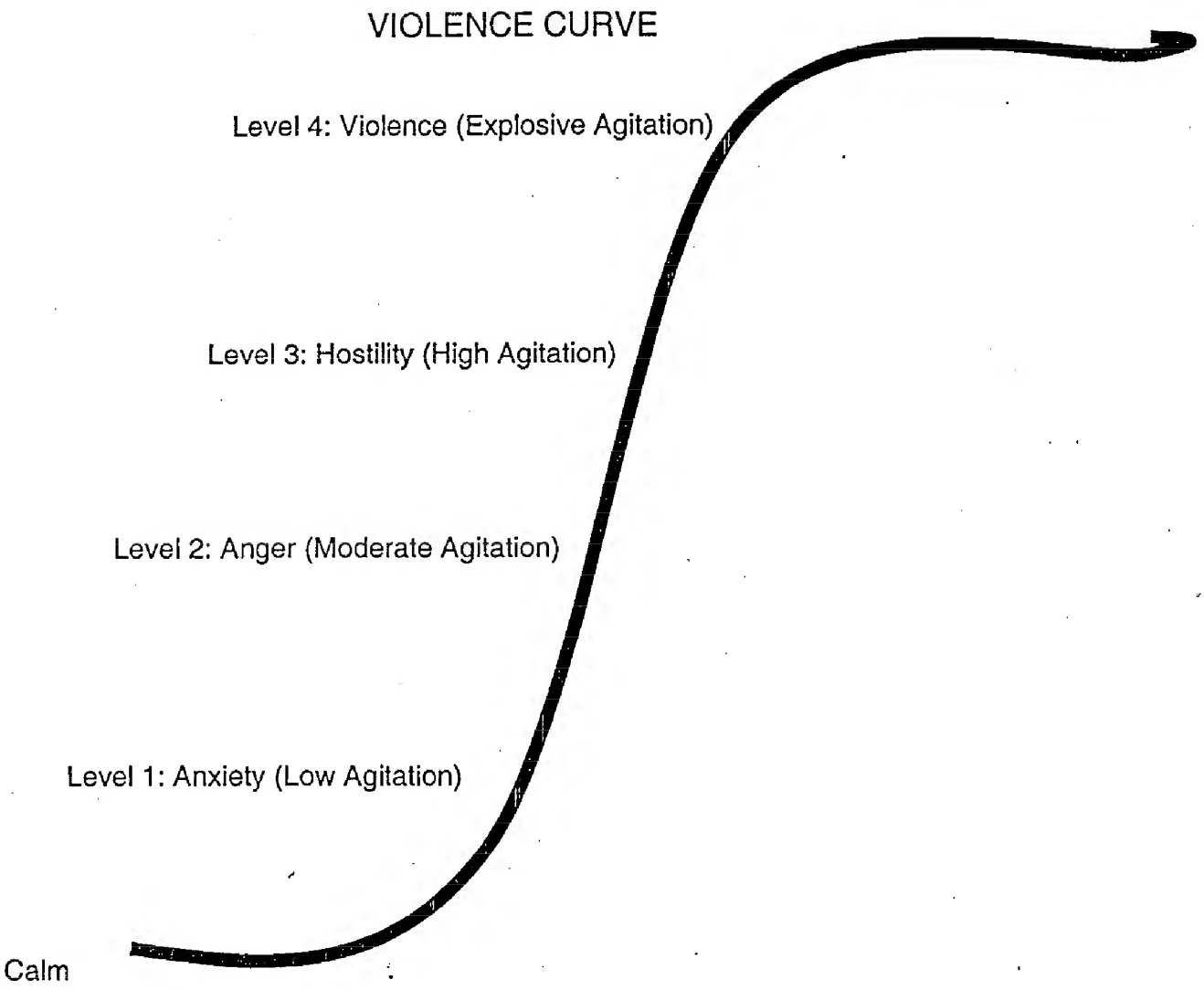


Communication
Communication is a people process. It is an interactive phenomenon, which involves more than words. Messages are often the result of a combination of words, behaviors, and context. Parts of the message are:

Verbal Components
1. Content
2. Speech
   - Rate productivity
   - Tone
   - Volume
   - Congruency with other messages

Nonverbal Components
1. Stance
2. Gestures – transient movements of the body or face
3. Eye movements
4. Facial expressions
5. Personal attire
6. Motor movements

Factors that influence communication
1. Culture/ Religion
2. Sex roles
3. Social class
4. Perceptions or internal experiences
5. Values



The above violence curve does not take into consideration variables of acute mental illness or intoxicants or both. Behaviors of individuals so affected will be erratic and tend not to follow progressive patterns.

CONCRETE THINKING

SUSPECT/ PERSON	CIT OFFICER RESPONSE
LEVEL 4: VIOLENCE	ANGER / FEAR
LEVEL 3: HOSTILITY	FEAR
LEVEL 2: ANGER	ANXIETY
LEVEL 1: ANXIETY	EMPATHY
CALM	SUPPORTIVE

Interaction
The escalation of violence chart describes the interaction and dynamic between the subject and officer. Both parties are human beings and are products of their upbringing, social norms, and survival instincts.

During the calm state of the violence chart, the subject is at ease. It is relatively easy to interact with such individuals even if they show perceptual distortions. When the subject shows anxiety as in level 1, it is not difficult to engage the person with a degree of sympathy or empathy. However, once the subject begins to exhibit symptoms of anger as in level 2, the CIT officer will normally experience symptoms of anxiety. When the subject is openly aggressive/abusive as in level 4, anger/fear may be the response.

The problem for both the subject and CIT officer is that as we move up the scale, the ability to effectively communicate diminishes. The subject's tunnel vision increases and thinking becomes more concrete as he/she gets more wound up. The officer likewise becomes more concrete as the stress level increases. The police officer has the additional disadvantage of needing to suspend emotions in order to perform well. Separating out feelings and increasing cerebral activity to

perform a technical function is common amongst emergency service workers. Unfortunately, this approach is counterproductive to the process of communication (which we described earlier as a people process interchange of ideas and feelings). The police officer must somehow bridge the paradox between suspending his/her emotions temporarily while listening for emotional cues in an effort to be effective.

The goal of the police officer in dealing with emotionally charged individuals is to pace and guide them into levels more conducive to mutual interchange. Communication skills for the police officer are like any other technical skill. Training and experience promote access to the skill — especially under emergent conditions.

Level 1: Anxiety
A subjective and uncomfortable emotion, which results from threats to the person. Accompanying feelings are dread and helplessness. The goal is to restore the person's sense of control by providing emotional support and negotiating an alternate action to the crisis.

Physical Attending Skills
- Facing the person squarely.
- Adopting an open posture.
- Leaning towards the person.
- Maintaining direct eye contact.
- Retaining a relaxed posture.
- Promoting a relaxing environment.

Responding Skills
- Emotional labeling
- Paraphrasing
- "I" statements
- Reflection / Mirroring
- Minimal reassurance
- Effective silence
- Open statements

Psychological Attending Skills
- What level of agitation did the patient display?
- What central theme concerned the patient?
- Was there evidence of drugs or alcohol that might interfere with predictability?

Intervention
- Negotiate through active listening

Level 2: Anger

Anger is a feeling state or emotion that serves to neutralize the helpless dread of anxiety. Anger can be functional in that the expression gives the person a sense of power. The danger is that anger can quickly escalate into physical expression or violence.

Angry people become less flexible in their ability to think. That is, they become more concrete as emotions rise. It is easier to understand that which can be touched or seen. Visual (nonverbal) messages become more important during stressful events. During stress periods, your verbal communication is required to be shorter, simpler, and more directive.

You goal is to keep the subject conversing with you and use time and your relationship to de-escalate the agitation.

Three Primary Techniques

1. Diffusing the adversarial emotion by acknowledging the anger. "I can see that you're very angry," or, "I'm sorry you're so upset." This has an impact when people become agitated and more concrete in their thinking because they automatically relate in terms of good or evil. That is, they may see themselves as victims and you as the aggressor. Acknowledging their concerns may serve to personalize and close this ever-increasing gap and provide you with a better chance of continuing an effective way of communicating. Remember, acknowledging the person's concern is not the same as agreeing with their position.

2. Advise giving or providing guidance in choosing a course of action or assuming a new role can help. Keep the advice very here and now, e.g. "you might be more safe on the sidewalk," or, "perhaps we could talk privately."

3. Provide choices. Offer a different course of action (A or B) or, one course of action that the person may choose to do or not (A or not A).

Remember that nonverbal interactions of posture, eye contact, tone, volume and pace are very important in the process of de-escalating the person.

Physical Attending Skills

- Facing the person at a 45-degree angle.
- Adopt an open posture
- Lean in to listen
- Maintain direct eye contact.
- Retain relaxed posture
- Promote a relaxing environment

Responding Skills

- Respect

- Empathy.
- Genuineness
- Speech Delivery
- Volume
- Calm Tone
- Productivity — keep dialogue simple.
- Content focus — keep immediate to the key issue.
- Pace speech to slow the person's agitated tempo.

Psychological Attending Skills

- Analysis
- What level of agitation.

Drugs and alcohol

- What central theme concerns the person?
- Can the anger issue be identified?
- What level did you leave the person?

Intervention

- Diffuse the adversarial momentum by affirming the anger.
- Advice giving. Directing to follow your good plan.
- Providing choices. Either A or B. A or –A.

Level 3: Hostility

Hostility is anger with a focused recipient. Hostile people are easy to detect. They are more openly irritable, demanding, argumentative, antagonistic or oppositional. Their voice volume can often be loud and threatening. This is the next stage to violence and must be dealt with caution given the potentially quick transition time. The subject is very concrete and more reliance is placed on the police officer's nonverbal and brief response. The goal is to obtain immediate control of the situation and diffuse to a less agitated (more manageable) stage.

The hostility stage is highly dynamic and the subject may move about displaying varying intensities. Each intervention episode should be less than 60 seconds in duration and often needs to be repeated before successfully diffusing the person/subject to the anger stage.

Four techniques in gaining control of the situation

1. Limit setting: Clearly state the boundaries of behavior that you will allow. "I need for you to lower your voice," "please step outside," "I need for you to leave," "please step back, I'm uncomfortable with you so close." The nonverbal approach is serious, professional, and authoritative. Hand signals are used to communicate. The verbal tone and volume are consistent with

the serious message. Sentences are less than 5 words and repeated rather than elaborated.

2. Diffuse the adversarial stance by acknowledging the anger: Timing is critical. Immediately (microseconds) following limit setting, or "punching a hole" in the defensive tirade. Affirm the individual by acknowledging his/her emotional state. This is a critical test point. If the subject/person accepts ("damn right I'm angry), then continue to dialogue using verbal and nonverbal skills to move to the more manageable Anger Stage. However, if the subject/person continues unabated despite repeated tries, be concerned that the escalation may result in violence.
3. Provide directives: Firmly tell the individual what you want him/her to do.
4. Give Warning: Clearly state as neutrally as possible the consequences of a given course of action.

The approach

1. Dealing with potentially violent people is frightening. You might be as charged as the subject. Try to maintain control by purposely taking deep breaths. Remember that you are going to try and regain control of the situation by communication. It isn't going to impress anyone if you squeak out your directives with residual air.
2. Approach the subject squarely from the side to avoid direct kicks. Keep an open posture (to avoid being perceived as attacking) and keep your hands out of your pockets.
3. Keep approximately two arm lengths distance from person.
4. Do not attempt to communicate by touch.
5. Maintain eye contact and an upright posture in an effort to convey control. Communication is continuous. The eyes coupled with facial gestures may provide advance warning of attack.

The Interaction

1. Do not engage in accusations, arguments, and demands for justification from the subject. This will result in a power struggle, which will prove futile. Winning arguments is not as important as fulfilling the job that you were called on to perform. Do not succumb to their baiting.
2. Work as a team, which may be part of a prearranged set of actions in dealing with emergent situations. Don't get maneuvered into being split apart as good guy, bad guy. "I can't talk to this cop. He's a jerk. I can see that you are a reasonable person. Can we privately discuss my request?"
3. Keep your verbalizations short and simple. Remember that the subject is operating very concretely and will only hear portions of what you will try to verbalize. Repeat your short request as opposed to paraphrasing.
4. Define clear expectations for the subject and communicate these positively and firmly.
5. Limit or address only those behaviors that clearly interfere with the client's welfare or the rights of others.

6. Confine the limits only to those that can be carried out. Empty limits only reinforce the patient's notion that you can not be relied upon. Likewise don't promise that which you cannot deliver. You will only be setting someone else up for potential violence.
7. Practice pat phrases and have them available. Under stress, it is more difficult to be creative. Timing your response is important in disarming an aggressor.

Physical Attending Skills

- Face the person squarely but approach at a 45-degree angle.
- Open posture. Keep your hands out of your pocket.
- Upright Posture. Denotes seriousness and control.
- Relaxed Posture. Denotes lack of intimidation.
- Do not communicate by touch.
- Maintain eye contact — look for advance warning of attack.
- If you point at an object or area, do not take your eyes off the subject.
- Remain two arm lengths away.

Responding Skills

- Genuineness
- Respect
- Speech Delivery
- Volume: Avoid shouting.
- Tone: Confident, assured and serious. Avoid challenging and condescending inflections.
- Rate: Purposely slow to de-escalate.
- Productivity: Keep sentences very short and simple.
- Repeat rather than elongate.
- Content: Here and now. Focus on your directive.
- Do not get "baited" into justifying or arguing.
- Avoid discussions leading to splitting. Confine warnings or promises to those that can be carried out.

Psychological Attending Skills

- Analysis
- What level of agitation?
- Have the person been using drugs and/or alcohol?
- What themes are being presented?
- Any "baiting or key words?
- What level did you leave the person?

Intervention

- Limit setting. Clearly state the boundaries of the behavior you will tolerate.
- Acknowledge the anger and focus.
- Provide directives. Firmly tell the individual what you want him/her to do.
- Warning. Clearly state as neutrally as possible the consequences of his/her behavior.

Level 4: Violence

Response Guidelines

Violence is aggression with a focus on destruction. Violence has injury as its goal. Violence may be verbal (if disruptive or hurtful enough) and/ or physical. The goal is to protect oneself. The goal is not to win but be useful at another time.

The Interaction

- Let your face drain of gestures
- Drop your shoulders indicating relinquishment
- Remain at 45-degrees to the person
- Don't make any sudden moves
- Don't take insults and taunting personally
- Don't be baited
- Do not take your eyes off the patient
- Clearly indicate to the aggressor that you intend to disengage and withdraw, e.g. "I quit, " or" "I'm out of here" messages
- Start moving away towards your escape
- Move slowly and methodically
- Continue your verbal and non-verbal communication to indicate retreat
- You can remain at bay waiting for reinforcements to arrive or totally withdraw.

Active Listening Concepts

Listening for Emotions

People communicate on two levels:

- Content — the simple facts
- Emotions — the emotional reaction to the facts

Train yourself to listen for the emotional message behind the content. Emotional reaction and subsequent behavior make the situation a crisis, not the fact of the situation. How a person feels about a situation will strongly influence what he/she does. Controlling the subject's emotions will help control the subject's behavior.

Listening for Values

- What people think are important
- What people prize

There may be a need to clarify the subject's values. Values influence behavior. The crux of the situation may be a value conflict.

Active Listening Skills

- Emotional labeling
- Paraphrasing
- Reflecting / Mirroring
- Effective pauses (silence)
- Minimal encouragers
- "I" Messages
- Open-ended Questions

Emotional Labeling

- The first active listening skill to be used in an incident.
- The intent of emotion labeling is to respond to the emotions heard in the subject's voice rather than content.
- Demonstrates that you are really listening and tuned into what the subject is emotionally experiencing.
- Do not tell a person how they are feeling, but rather how they *seem* or *sound* like they are feeling to you.
- Do not be afraid to label emotions incorrectly.
- Be aware of missing emotions.
- Listen for conflicts in the feelings expressed.
- Never hesitate: label every emotion you hear.
- Note when the emotions are inappropriate to the situation described.
- Be aware of your emotions and what the subject is hearing from you.
- Use throughout the negotiation / intervention whenever you hear emotions expressed.
- Do not use when you are being verbally attacked.

Emotional Labeling Examples

- You sound _____
- You seem _____
- I hear _____

Paraphrasing

- A summary in your words as to what you were just told.
- Demonstrates you are listening.

- Creates empathy and rapport because it demonstrates you have heard and understand.
- Creates empathy and support.
- Clarifies content, checks perception, and highlights issues.
- Obtains additional intelligence.

Paraphrasing Examples
- Are you telling me...
- Are you saying...

Reflecting / Mirroring
- Repeating back the last word or phrase the subject just said.
- Gives feedback that is very exact.
- Asks for more intelligence without guiding the direction.
- Gets intelligence when you do not have enough to ask a good question.

Effective Pauses (Silence)
- An effective pause is silence.
- Silence is effective if it serves your purpose.
- Most people are not comfortable with silence and will fill it with talk.

Uses of Silence
- When you are about to say something important.
- When you have just said something important.
- When the subject is trying to "psych" you out.

Minimal Encourages
- The sounds you make, especially on the telephone, to let the other person now you are present and listening.
- May be short questions such as: "really?", "Oh?", "When?"
- Does not interfere with the flow of the conversation.
- Lets the subject know you are present and listening.

Uses of Minimal Encouragers
- Helps build rapport.
- Encourages the subject to continue talking.

"I" Messages
- Enables us to let the subject know how they are making us feel, why we feel that way, and what they can do to remedy the situation.
- Conveys the above information in a non-threatening way and does not put the subject on the defensive.

Uses of an "I" Message

- When communication is difficult because of the intense emotions being directed at you.
- When the subject is making communication impossible.
- When you need to refocus the subject.
- When you are being verbally attacked.

Examples of "I" Messages

- I feel _____(emotion or feeling)
- When you_____(his/her behavior)
- Because _____(your reason)

Open-Ended Questions

- Questions that cannot be answered with a "yes" or a "no."
- To obtain information without asking a lot of questions.
- Usually begins with the words: how, what, when, where.

Uses of Open-Ended Questions

- To help a subject start talking.
- To elicit examples of specific behavior.
- To obtain additional intelligence.
- To focus on the subject's feelings.

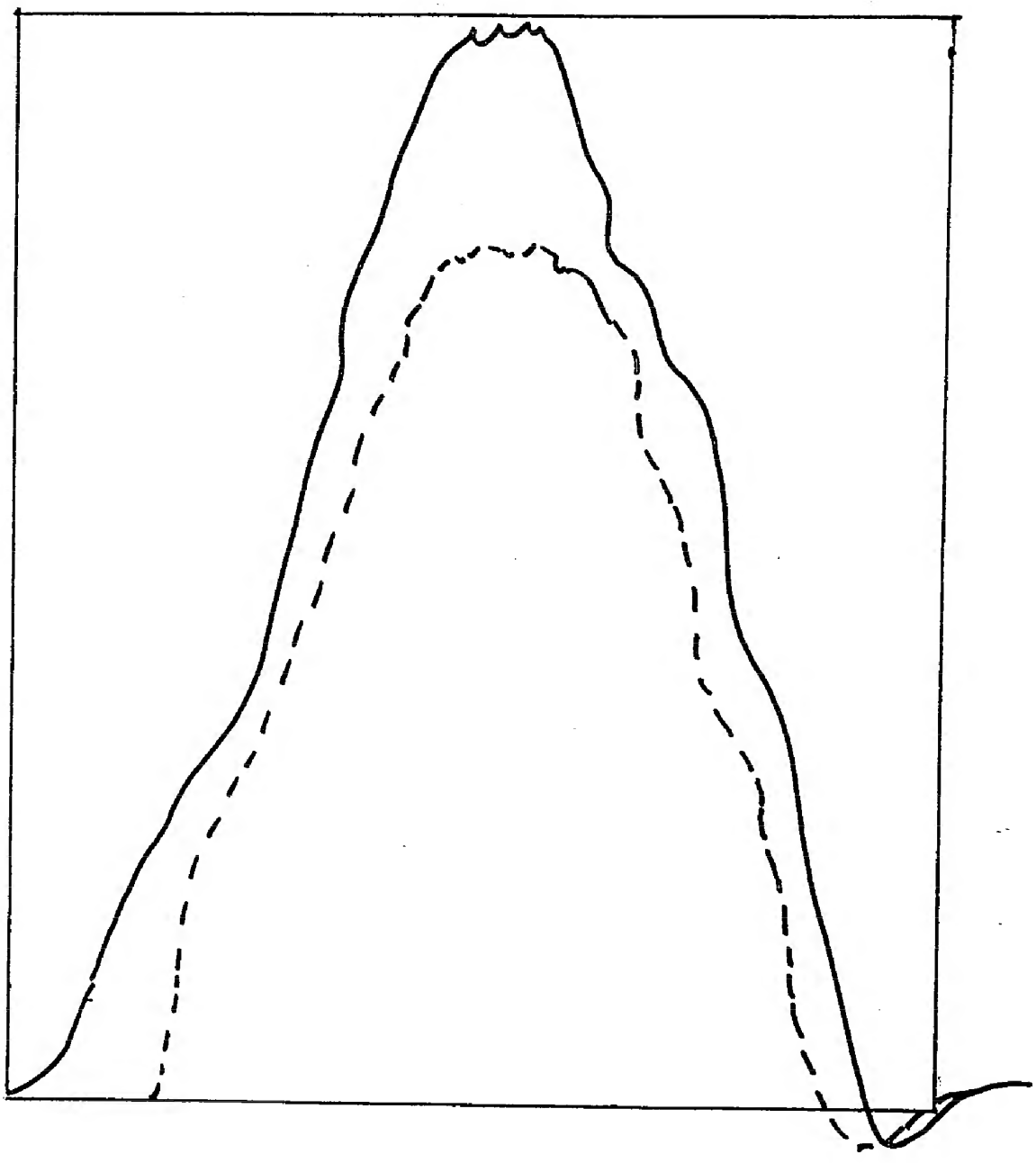
Problems Caused by Closed-Ended Questions

- Gives a feeling of interrogation, which makes rapport difficult to build.
- Causes you to work harder thinking up new questions.

NOTES

INTERVENTION IN THE CRISIS CYCLE

Two crisis cycles juxtaposed



4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

INTERVENTION

A. APPROACHING THE SCENE
   1. Calls
   2. Information before you arrive
   3. Monitor your own emotional state
   4. Leave prejudices/bias/predisposition behind

B. ON THE SCENE
   1. Assess the situation and stabilize, if necessary

C. CRISIS INTERVENTION
   1. Crisis cycle
      a. Intervention at each stage of the cycle
      b. Different levels of understanding, perception and development at each stage
         (1) Look at face, voice and posture for signs of what level
      c. Stages of cycle
         (1) Normal state
            (a) 100% perception and ability to reason
            (b) Acts as an adult
            (c) Person experiences no emotional content
            (d) Officer is calm
            (e) Can problem solve
         (2) Stimulation (internal/external)
            (a) 50-75% perception and ability to reason/understand
               1) Agitated behavior
            (b) Acts as a teenager
            (c) Person experiences anxiety
            (d) Officer is calm
            (e) Action officer should take
               1) Use simple sentences
               2) Use calming body language
               3) Keep voice low and calm
         (3) Escalation
            (a) 5-24% perception and ability to reason/understand
               1) Loud, aggressive, flushed
            (b) Acts as an 8-year old having a tantrum
            (c) Person experiences fear; frustration
            (d) Officer is anxious
            (e) Actions officer should take
               1) Use sentences of less than 5 words
               2) Make one immediate request
               3) Repeat continually
               4) Body language and voice firm but calm
         (4) Crisis
            (a) 0-5% perception and ability to reason/understand
               1) Out of control

(b) Acts like "terrible two's"
(c) Person experiences anger
(d) Officer is fearful/frustrated
(e) Actions officer should take
1) Use firm, one sentence commands
2) Repeat continually
3) Make decision regarding use of physical force

(5) De-escalation
(a) As consumer de-escalates, officer uses the same techniques down the de-escalation
(b) Consumer may suffer post-crisis depression
(c) Escalation can cycle up and down

(6) Things to remember
(a) Take your time
1) Person cannot remain in crisis state forever
(b) Constantly read feedback from consumer
(c) Stop doing anything that escalates the consumer
(d) Continue anything that de-escalates the consumer

(e) Have only one officer talk to the consumer at a time
1) Trade off if not effective

2. Communication skills

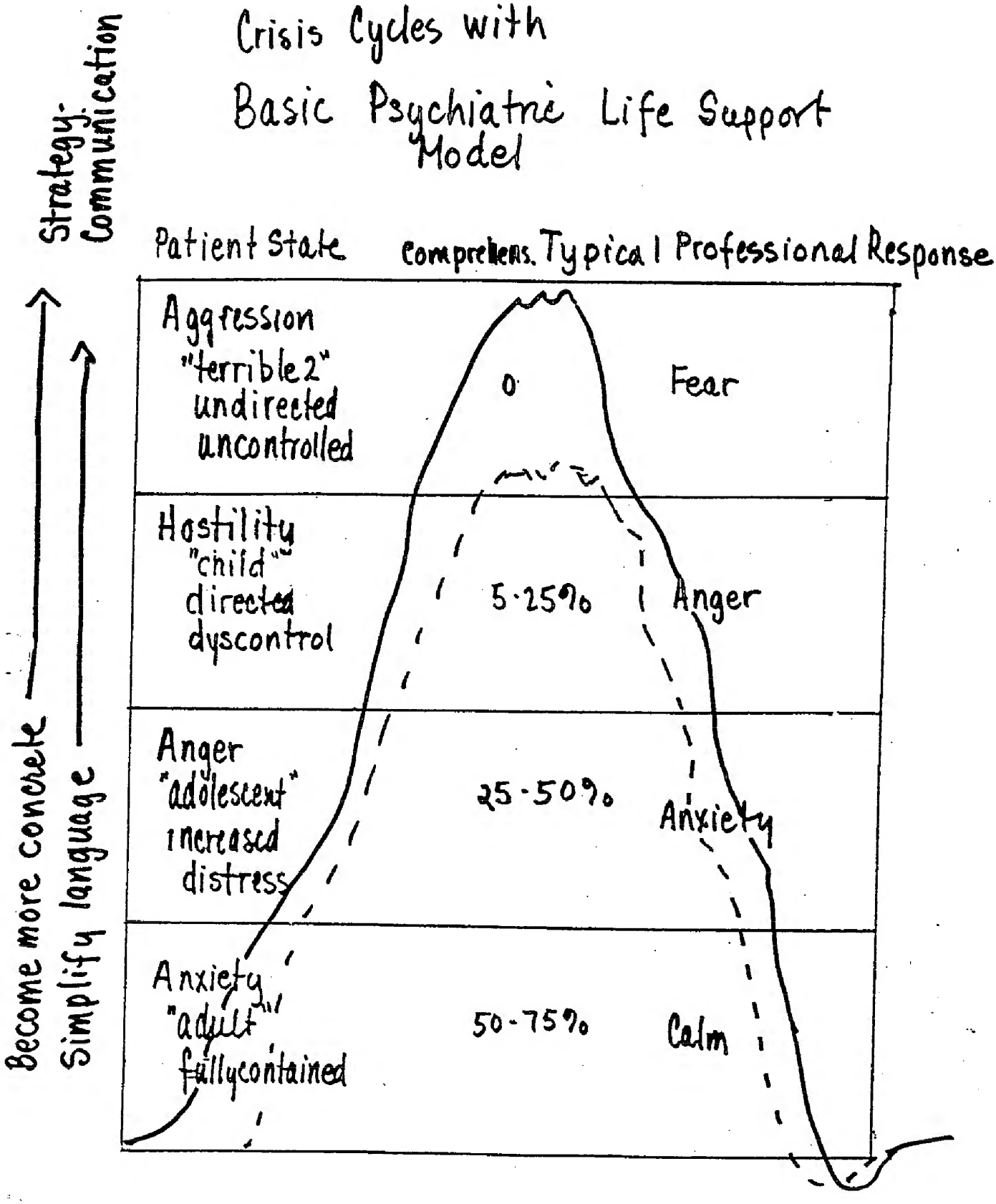
a. Verbal skills

(1) Tell person you are there to help
(2) Introduce self by first name
(3) Ask and use their name
(4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
(5) Ask clarifying questions in terms of "I" statements
(a) "I don't understand this"
(b) "I'm afraid you'll hurt yourself"
(c) "I can't figure out why"
(6) Use personalized statements
(a) "Your holding that rock makes me nervous"
(7) Do not argue
(8) Actively listen
(a) Do not be afraid of silence
(b) Wait for responses
(c) Echo their feelings "You seem to be angry"
(9) Show concern and understanding
(a) Nod head while they are talking; indicate listening with "I see", "Uh, huh", etc.
(10) Treat person with respect
(11) Do not use offensive terms or sarcastic remarks
(12) Tell people what you are going to do
(a) Do not make promise you cannot keep
(13) If person becomes agitated, change subject

b. Non-verbal skills
   (1) Feedback loop
      (a) Watch reactions of consumer to you
      (b) Stop action if escalates consumer
   (2) Open body language
      (a) Rule of palms
         1) Palms open
      (b) Stand slightly to the side/bladed
      (c) Take safe, but not defensive stance
         1) More relaxed posture
         2) Head tilted
         3) Be ready/appear relaxed
      (d) Keep hands off paraphernalia
   (3) Eye contact
      (a) Try to make eye contact
         1) Some people like it as sign of personal contact
         2) May make some people nervous
      (b) Try to remain at eye level
   (4) Body space
      (a) Rule of 3
         1) Remain 3 arms length away at first contact
      (b) May need to move in to establish personal contact
   (5) Move slowly
      (a) Announce action to consumer
c. Questions to ask
   (1) Ask what is happening that caused crisis
   (2) Ask about past history
      (a) Case worker
      (b) Counselor
      (c) Treatment
   (3) Ask how they resolved similar situations in past
   (4) Ask what clinic they go to or where they go for treatment
   (5) Ask if they are taking medication(s)
   (6) Ask the names of their medication(s)
   (7) Ask if they would like to see a doctor
   (8) Ask if they are thinking of taking their own life
      (a) How
      (b) Do they have the means (gun, knife, pills)
      (c) Have they ever tried it before
   (9) Ask if they are hearing voices
      (a) Are they telling you to do something
d. Officer safety reminders
   (1) Never deny the possibility of violence
      (a) Persons with mental illness are not more violent than the "normal" population but may be more unpredictable
   (2) If hearing voices, ask what the voices are saying

(3) Keep relaxed approach, but not complacent
(4) Watch consumer's hands
(5) Upon transport, always handcuff even if this risks re-exciting the subject; tell the person what you are going to do and why

Crisis Cycles with Basic Psychiatric Life Support Model



Course Title: Mental Retardation and Developmental Disabilities: Basics For Police Officers

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 3:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To familiarize officers with characteristics of individuals with developmental disabilities, and how these characteristics may affect officer interactions with individuals.

Performance Objectives:

The officer will demonstrate knowledge of what mental retardation is and distinguish it from mental illness

The officer will be able to identify some characteristics of persons with mental retardation in each of the following areas: communication, interaction, judgement/knowledge; performance abilities.

The officer will be able to list some implications of the above characteristics in managing interactions with victims, suspects, and witnesses.

The officer will demonstrate knowledge of how to identify paid or unpaid helpers of a person with a developmental disability.

Course Outline:

Definitions

1. Mental retardation
2. Developmental disability
3. Distinguishing mental retardation from mental illness
4. Other disabilities that affect cognitive functioning

Some characteristics of individuals with mental retardation

A. Recognition of disability/managing the encounter
B. Wide individual variation in each area.
   C. Communication issues
   D. Interaction issues
   E. Judgement/knowledge isssues
   F. Performance abilities

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fully contained

Fear

A perceived need (sometimes irrational) to escape, defend against, or eliminate a perceived threat of personal injury.

Visual signals

Posture: Tense and prepared to defend, hide or run away.

Skin color: Pale or ashen.

Facial expression: Wide-eyed and fearful.

Auditory signals

Voice quality: Whining, pleading, gasping, bursts of speech, may be unable to speak.

Breathing: Rapid, shallow, irregular.

Confirming history

Personal history of abuse / victimization and/or withdrawal, sometimes punctuated by assaultive outbursts.

Crisis Intervention for: Fear

Goal: Threat Reduction

The basic assumption is that communication patterns that reduce the perceived threat will also reduce the probability that the assault will escalate to battery. Conversely, communication patterns that add to the perceived threat can be expected to increase the probability of battery. Here are some guidelines for reducing threat:

Posture: relaxed and open; hands in full view

Gestures: slow, palms-up

Position: slightly off to the side of the fearful client, and far enough away (8-10 feet, if possible) to make it clear that an attack on the client is not being planned.

- positions directly in front of, or any position behind a frightened person can be expected to increase the perceived threat
- positions at or below the eye level of the frightened person can be expected to reduce the perceived threat

Voice quality: firm, reassuring, confident

Speech content: logical, encouraging calm reflection; promising to help if possible, but not promising something that is not possible

Eye contact: if the frightened person seems to seek eye contact as an additional source of reassurance, it should be given freely; if the frightened person tries to avoid eye contact it should not be forced on them. There are many cultures that discourage or limit communication through eye contact.

Physical contact: some frightened people (particularly children) need to have reassurance communicated through touch. Touch should be "offered", not given without permission, and should be light with slow movements.

Frustration

An irrational attempt to gain control by physically attacking the source of frustration.

Visual signals

Posture: Tense and prepared to attack.

Skin color: Tones of purple or red; splotches.

Facial expression: Tense, focused, and angry.

Auditory signals

Voice quality: Menacing, aggressive, loud.

Breathing: Loud, deep, long, heavy.

Confirming history

History of low frustration tolerance, coupled with impulsiveness.

Crisis Intervention for: Frustration

Goal: Control

The basic assumption is that patterns of communication that demonstrate and "lend" control will contribute to the restoration of the internal control of the frustrated client. Conversely, communication that demonstrates loss of control will likely increase the probability that the frustrated person will lose their ability to control an impulse to attack. Here are some guidelines for exerting control:

Posture: self-confident, commanding

Gestures: firm, commanding, palms out or down

Position: directly in front of the frustrated client, and just outside of his/her striking range.

- A position within striking distance of a frustrated person communicates a challenge or a desire to fight.
- A position well outside of striking distance of a frustrated person communicates undue caution or fear, and unwittingly points out vulnerability and willingness to be a target for release of frustration.

Voice quality: quiet, firm, commanding in tones low enough to make the frustrated person strain to hear

Speech content: repetitive, confident commands without threat

Eye contact: direct and accompanied by facial expressions which indicate that a firm command is being given.

Physical contact: if physical contact is required to prevent the frustrated person from escalating from assault to battery, it should be made firmly but without excessive movement or pain that would indicate loss of control.

Manipulation

An indirect attempt to obtain or avoid something in exchange for not losing emotional control. Manipulation becomes dangerous when assault is used as a tool in the attempt. Remember: Beneath every manipulative demand there is a legitimate request. Manipulation can take a variety of forms, including:

The temper tantrum

In this case the manipulating person starts by making a calm, but unreasonable (given the circumstances) request. When the persons' requests / demands are not met, they threaten violence by appearing to lose control: yelling, banging, stomping, etc.

Playing the numbers

In this case the manipulating person attempts to "play" people against each other, hoping that in the confusion their request / demand will be met. Group care settings provide an abundance of opportunities for this form of manipulation.

Promoting confusion

In this case the manipulating person brings in related, but irrelevant, matters into the discussion, leaving the professional wondering what the client really wants, or how the issues being raised by the person relate to the request / demand being made.

Visual and auditory signals

Although the signals are often difficult to interpret at any particular moment, there is a definite and recognizable pattern :

- The initial set of signals often occur in a whining voice, usually with a "gimme" attached, and with the affect of a pitiable victim.
- If that doesn't work, the next step is a series of marginally related accusations, comparisons, and other trivia, uttered in more aggressive tones.
- If that doesn't work, the next step is threats and actions against property.
- Finally, when all else has failed, assault is attempted.

Confirming history

A history of losing control or attacking physically when feeling deprived or oppressed.

Crisis Intervention for: Manipulation

Goal: Detachment

The basic assumption is that communication patterns that tend to indicate refusal to become involved in manipulation will decrease the likelihood that the manipulative person will attempt to gain something through complete loss of control resulting in battery. Conversely, communication that indicates openness to the manipulative demand increases the belief that the demand will be met at the next higher level of loss of control. Here are some guidelines for detaching yourself from a manipulative game:

Posture: closed, relaxed

Gestures: idiosyncratic gestures of disapproval or mild irritation (toe or finger tapping, eye rolling, "disgusted" sighing and nodding, arm folding, etc.)

Position: close enough to physically intervene if necessary, but far enough away to show non-involvement (4-5 feet)

- turning slightly away to show non-involvement is appropriate, but do not turn your back

Voice quality: detached, mechanical, slightly bored

Speech content: quiet, repetitive, "broken record" commands

Eye contact: avoid eye contact by looking at the hairline, chin, shoulders, etc.

Physical contact: if physical contact with the person who is manipulating becomes necessary, it should be handled as quickly and unemotionally as possible. Try to make contact with clothing only, not flesh. Punitive and vengeful forcefulness should be avoided, since it will add to the belief that the manipulation could have been successful if it had been done differently.

Intimidation

A calculated attempt to get something in exchange for physical safety or freedom from the threat of injury. "Don't make me hurt you" is the flavor of the message you get from many of the people who intimidate.

Visual and auditory signals

Basically neutral or unremarkable, with the exception of a menacing voice quality and/or threatening words and posture. Often people who are attempting to intimidate use physical menacing / crowding (standing very close to or over the person being intimidated) as a way to threaten danger.

As in manipulation, there is a definite and recognizable pattern of change in signals:

- First, there is a clear and often strongly stated demand.
- If the demand isn't met, this is followed by a believable threat of physical injury coupled with a reminder that injury can be avoided by complying with the demand.
- Finally, refusal to comply or delay in complying is followed by the attempt to injure through assault.

While we often respond to attempts to manipulate with annoyance and irritation ("here we go again", or "give me a break"), we often respond to intimidation with fear and a belief that we might really get hurt!

Confirming history

A history of bullying, extortion, and other criminal assault.

Note: This form of assaultive behavior is often used by persons diagnosed as "anti-social personalities" or "sociopaths".

PRECAUTIONS (DON'TS)

REMEMBER, DON'T:

1. Deny the possibility of violence when early signs of agitation are first noticed.
2. Underestimate information given by others regarding behavioral clues.
3. Engage in behaviors that can be interpreted as aggressive.
4. Allow others to interact simultaneously while you are attempting to talk.
5. Make promise you can not keep.
6. Allow feelings of fear, anger, or hostility to interfere with self control and professional demeanor.
7. Argue, give orders, or disagree unless absolutely necessary.
8. Be placating by giving in and agreeing to all the real and imagined ills of the person.
9. Become condescending by using cynical, sarcastic, or satirical remarks.
10. Let your own importance be acted out in a know-it-all manner.
11. Raise your voice, put a sharp edge, or use threats to gain compliance.
12. Mumble, speak hesitantly, or use a tone so low that you can't be understood.
13. Argue over small points.
14. Attempt to reason with anyone under the influence of a mind altering substance.
15. Attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
16. Allow a crowd to congregate.
17. Corner, or be cornered: give the person expanded space.
18. Ask why?
19. Deny the opportunity to save face.
20. Rush, be rushed, or lose your own cool!

RESOLVING CRISIS

02/09/95

1. INTRODUCE YOURSELF. PERSONALIZE CONTACT. "MY NAME IS JOHN. WHAT'S YOURS?"

2. USE A CALM VOICE.

3. UTILIZE RELAXED BODY LANGUAGE.

4. TELL PERSON YOU ARE THERE TO HELP THEM.

5. AVOID ARGUING.

6. SHOW GENUINE CONCERN BY ASKING MANY QUESTIONS.

7. ASK THE PERSON WHAT IS HAPPENING RIGHT NOW TO CAUSE THIS CRISIS.

8. ACTIVELY LISTEN. REPEAT BACK WHAT YOU HEAR THE PERSON COMMUNICATING ABOUT THEIR FEELINGS. REPORT BACK TO THE SUBJECT THE EMOTION YOU THINK THEY ARE FEELING. "YOU'RE FEELING ANGRY." "YOU'RE FEELING ANXIOUS." "YOU'RE FEELING FRIGHTENED."

9. ASK THE PERSON ABOUT HIS OR HER PAST HISTORY OF CRISIS.

10. ASK THE PERSON HOW THEY HAVE RESOLVED CRISIS IN THE PAST.

11. ASK ABOUT FRIENDS, RELATIVES, COUNSELORS, CASEWORKERS OR OTHER POSSIBLE SUPPORT PEOPLE.

12. OBSERVE THE SUBJECTS BODY LANGUAGE.

13. IF THE PERSON BECOMES MORE AGITATED CHANGE THE SUBJECT.

14. STATE CLARIFYING QUESTIONS IN TERMS OF THE OFFICER HAVING A PROBLEM:

"I DON'T UNDERSTAND THIS . . . "
"THAT ROCK IN YOUR HAND MAKES ME NERVOUS."
"I'M AFRAID YOU'LL HURT YOURSELF."
"I CAN'T FIGURE OUT WHY . . . "

15. GIVE INFORMATION. EXPLORE OPTIONS WITH SUBJECT.

16. TREAT PEOPLE WITH RESPECT.

17. TELL THE PERSON WHAT YOU ARE GOING TO DO TO HELP THEM.

18. ALWAYS KEEP YOUR WORD.

THE RULES

1- THE RULE OF TIME

2- THE RULE OF THREE

3- THE RULE OF FIVE

4- THE RULE OF PALMS

5- THE RULE OF ECHOS

6- THE RULE OF CALM

CRISIS INTERVENTION WITH PERSONS WITH DEVELOPMENTAL DISABILITY

NOTES

Course Title: The Crisis Cycle

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 4:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To introduce the crisis cycle as a model for understanding the stages of crisis. Implications for interventions will be discussed.

Performance Objectives:

1. The officer will be able to identify the stages that a person goes through when in crisis.

2. The officer will be able to identify and list typical emotional responses of officers intervening in crisis.

3. The officer will identify the language comprehension levels accompanying crisis stages and the implications for intervention.

Course Outline:

The Crisis Cycle: the emotional and behavioral stages people experience when in crisis (Oregon Intervention System model

0. Normal State
1. Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post-crisis depletion
6. Stabilization

The Escalation Grid (Basic Psychiatric Life Support Model)

1. Anxiety
2. Anger
3. Hostility
4. Aggression

How the Crisis Cycle and the Grid fit together

1. Emotional and behavioral interactions
2. Two crisis cycles juxtaposed
3. The Grid- typical responses of professional interveners

A. Anxiety- calm
B. Anger- anxiety
C. Hostility- anger
D. Aggression- fear

4. Recognizing your own responses
5. Setting aside your own responses

The effect of emotional state on communication

1. Comprehension decreases as control decreases
2. Implication for intervention strategies
   A. "adult", "adolescent", "child", "terrible 2"
   B. Simplify language
   C. Become more concrete

G. Effects of the system

Implications of characteristics

Finding out if there is someone who can help

1. Who are the players?
2. What questions can you ask to get useful information?

WHAT ARE MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES?

Definitions. There are many different definitions of mental retardation and developmental disabilities. Agencies typically have their own complex definitions, which may differ from agency to agency. The definitions below are "unofficial.

Mental Retardation. Intellectual functioning that is significantly below average, along with substantial limitations in adaptive behavior (for example, ability to independently perform activities of daily living or function in society.) Mental retardation originates during the developmental period (before 18 in most definitions) and is likely to be lifelong. Generally, a person who has an I.Q. score of 70 or lower is considered to have mental retardation.

Note about terminology: many people do not like to have the term "mental retardation" applied to them, because of unpleasant history or associations. Some prefer the term "developmental disability" or "cognitive disability". Some refer to themselves as "slow" or a "slow learner".

Developmental Disability. This is a broader term than mental retardation. A developmental disability is a disability caused by a neurological condition. It originates during the developmental period, it is likely to be lifelong, and it requires training and support similar to that needed by a person with mental retardation. Besides mental retardation, common causes of developmental disability are cerebral palsy, epilepsy, and autism. **Cerebral palsy** is a catchall term for a variety of disorders that affect a persons ability to move and to maintain posture and balance. Walking ability and speech are often affected. **Epilepsy**, also called seizure disorder, is a condition that causes seizures of various kinds. Some seizures cause a person to fall, lose consciousness, and have jerking movements of the whole body for several minutes. Others cause involuntary movements of a part of the body without loss of consciousness, and still others cause a brief loss of consciousness without falling. Mild forms of cerebral palsy or epilepsy are not considered developmental disabilities under the above definition. **Autism** is a severe developmental disability affecting communication, social interaction, and behavior.

Mental Illness vs. Mental Retardation. Mental retardation/ developmental disability is not the same as mental illness. Hallucinations and delusions are characteristic of some mental illnesses; they are not characteristic of MR/DD. Neither are mania or depression characteristic of mental retardation. A person with mental retardation can be expected to act rationally at their functional level. However, a person with mental retardation or another developmental disability may also have an additional disability such as a mental illness or a drug or alcohol addiction.

Other Disabilities. There are other disabilities and health conditions which affect cognitive (intellectual) functioning and which therefore may be confused with mental retardation. A disability from head injury to an adult is not mental retardation, nor is dementia from conditions such as Alzheimers or late stage alcoholism. A person who has recently had a seizure may have a short period of impaired functioning which may be mistaken for mental retardation.

Institutionalization. In the past, many individuals with developmental disabilities, even those with mild mental retardation were routinely institutionalized. Beginning in the late 1960's, it began to be generally understood that people with developmental disabilities had the right and the ability to live in the community. Programs such as group homes and semi-independent living programs were established to provide training and support in the community and people began coming out of institutions in increasing numbers. However, some people were discharged without appropriate

Do you want to call them now?
Is it OK if I call them?

If you are at a group home or foster home(or other situation in which someone seems to be in a staff role) in a crisis, and the staff seems to be unsure what to do:

Ask: Do you have someone you can call to help you in a crisis?
In a foster home there may not be anyone. In a group home or supported living situation, there should always be a way to contact administrators in an emergency.

SOME SUGGESTIONS FOR COMMUNICATING WITH A PERSON WHO HAS MENTAL RETARDATION

- Keep language simple, but not childish.
- Avoid abstractions or technicalities. Be concrete.
- Avoid yes/no questions, or questions that suggest the answer you expect.
- When you give instructions:
  - Give one at a time
  - Be clear and direct
  - Be sure the person understood. One way to do this is to ask them to repeat it back.
- Don't talk to others in front of the person, as if the person wasn't there.
- If the person has any reading/writing ability, write down simple reminders if they need to do something later. Ask if they have a calendar you can write it on.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

supports and others lost supports for budgetary or other reasons. The movement to "deinstitutionalize" people continues to the present. Today, Fairview and Eastern Oregon Training Centers are still in operation, but they are much smaller than they were in the past.

Being institutionalized affects people seriously. A history of being in an institution sometimes helps explain behaviors that are otherwise hard to understand. Usually the younger the person went into the institution, and the longer they remained, the more serious the effect. In an institution, people are deprived of the opportunity to learn what it's like to live in a regular family and community, and so it is much harder for them to develop appropriate social skills. They have limited opportunity to develop normal human relationships, and little modeling of how people act in normal situations. To survive, some people learned to comply with anyone who acted as if they were in a position of authority. The lack of privacy caused some not to have regard for their own privacy or that of others. For some, the lack of respect for their personal property taught them that if they valued something they needed to carry or wear it or it would be taken. People had few choices and little control over their own lives. Many people were sexually or physically abused by other residents or by staff, and they have the same kinds of problems other sexual abuse survivors have. These can include low self esteem, sexual acting out, lack of trust in others, Post Traumatic Stress Disorder and depression.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

SOME CHARACTERISTICS OF INDIVIDUALS WITH MENTAL RETARDATION: IMPLICATIONS FOR LAW ENFORCEMENT

In order to successfully manage an encounter with a person with mental retardation, whether a victim, suspect, or witness, it is important for the officer to recognize the disability. Recognizing the disability and managing the encounter are often one and the same.

Each person with mental retardation is an individual. People with the same measured I.Q., whether they have mental retardation or not, vary widely in their skills, interests, personality and communication style. Listed below are some characteristics that may be more likely to occur in a person with mental retardation. There won't be anyone for whom all (or even most) of these factors apply. For some individuals with mental retardation few or none will apply.

Communication issues

- Does not communicate at the level of typical persons of the same age group
- Limited vocabulary or limited grammatical skills
- Speech defect
- Unable to read or write or limited ability
- Difficulty understanding questions
- Difficulty answering questions; may give "standard" or "parrotted" responses
- Appears to understand when they do not, may not want to admit lack of understanding
- Fails to comply with rules; this may be due to lack of understanding

Interaction issues

- An excessive desire to please others
- Behavior on a level below the person's age
- Crowding personal space when interacting with others
- Tendency to be overwhelmed by authority
- Becomes hostile or withdrawn rather than admit lack of understanding
- Low frustration tolerance

Judgement/knowledge issues

- Does not fully understand seriousness of situations
- Limited safety awareness; may be easily victimized
- Judgements regarding "friends" are the most difficult
- Easily persuaded or influenced by others
- Lack knowledge on how to protect themselves

Performance abilities. May be limited in some of these areas:

- Reading and writing
- Using the telephone
- Understanding finances
- Making change
- Understanding need to budget to cover living expenses
- May give away money or belongings
- Following complicated directions

- Telling time
- Keeping appointments
- Managing activities of daily living , such as hygiene, housekeeping, cooking

Effects of our culture (or system) and common attitudes about disabilities
These are often as limiting as the effects of the disability itself.

- Praised for compliance
- "Protected" by being "kept in"
- "Protected" by not being given sexual information
- Not taught about their rights
- Segregated from others; heavily dependent on caregivers
- Abuse may not be taken seriously
- Live in high risk environments

SOME IMPORTANT IMPLICATIONS OF THESE CHARACTERISTICS
The victim who has mental retardation:

- Higher risk of victimization, especially for sexual assault and robbery
- May be victimized by caregivers or "friends"
- May not understand that what has happened is a crime or that law enforcement can help

The suspect who has mental retardation:

- May admit to things he/she did not do, in order to comply or please
- May have been a follower or coerced by persons with higher abilities
- May not understand what you tell them about their rights (Miranda warnings)

Suspects, victims, and witnesses

- May tell you what they think is the "right answer"

FINDING OUT IF THERE IS SOMEONE WHO CAN HELP
This may also help you determine what the disability is.

Ask: Do you have a Case Manager?
Do you have their card?
(if no card) Who do they work for? Where is their office?

Ask: Is there someone who is paid to help you?(with money, making appointments, fixing meals,etc)
Do you have their card?
Do you have their phone number?
Would you like to call them now?
Is it OK if I call them?

Ask: Do you have a family member that helps you with things? A neighbor? Someone else?
Do you have their phone number?

Multnomah County Developmental Disabilities Services Division

"WHAT ARE ALL THESE PROGRAMS AND WHO'S IN CHARGE HERE ANYWAY?"

The Developmental Disabilities Services Divison (DDSD) is part of the Multnomah County Department of Community and Family Services. Until recently DDSD was called the "Developmental Disabilities Division" and before that, the "Developmental Disabilities Program". Offices are in the Commonwealth Building, 421 SW 6th, Suite 400, Portland, OR 97204, (503) 248-3658. Office hours are Monday through Friday 8:00 to 5:00 P.M.

The Division provides case management for eligible individuals. It also contracts with private providers (some non-profit and some for-profit) to provide residential and vocational services to some individuals. These residential and vocational services are funded mostly with state and federal money, and are under many state and federal regulations. The state and the county both have oversight responsibility for these programs.

Case Manager - Everyone served by the Division has one. This is the person in the Division who works directly with the individual, the family (especially for kids), and any residential, vocational, or other programs that the individual participates in. **This is who you should ask for when you need help for a particular individual.** The Division no longer calls case managers "case managers", but many other people do, so if you ask for the case manager, everyone will know who you're talking about. These people are now mostly called:

Family Consultant (for children)
Service Coordinator (for adults)

If a person urgently needs help and the case manager is not available, there is a **Backup Worker** available during business hours.

Protective Services Investigator - A specialized case manager who investigates allegations of abuse or neglect of adults served by the Division. (Services to Children and Families – SCF- investigates for children.) Police may deal with a Protective Services Investigator if the abuse or neglect involves criminal behavior. To make a Protective Services referral, report the suspected abuse to the individual's case manager (or the Backup Worker) and a Protective Services Investigator will be assigned.

Managers and supervisors - Every Service Coordinator/Family Consultant has one. You can ask for the supervisor if you can't get what you want from (or can't reach) the Service Coordinator/Family Consultant or the Backup Worker.

Division Manager - The person in charge of the Division.

RESIDENTIAL PROGRAMS

These are the programs that provide support in day to day living for some individuals with developmental disabilities. **Most individuals with developmental disabilities do not have any paid supports; they live by themselves or with friends or family.** There are many who need or want services which are not available due to funding constraints.

24-hour Residential ("Group homes")- These programs provide 24 hour staffing for support of individuals. The "typical" program is a 5- person group home. A few are larger. Some are "apartment model". In those, the staff will be present in the complex, but often not in the individual's apartment. **The people who work directly with individuals are generally called "direct care staff", although** in some agencies, they have other titles like "Community Support Specialist". Typically they work shifts and do not live in the home, although there are exceptions. **Group Homes typically have a house manager or site manager. The direct care staff should be able to reach the house manager or another administrative staff person by phone or beeper at all times, and you may want to ask them to do so if there's a problem.**

Semi-Independent Living Programs (SILP)- A program that provides support (typically 2-4 hours per week) to individuals who live in their own apartments. The individual has telephone access to a staff person in emergencies. If you think an individual may be in a SILP program, you may want to ask them if they have a staff person they can call.

Supported Living - A program that's more individualized than 24-hour residential programs but typically provides more support than SILP. There may be live in staff or "paid roommate", or direct care staff working shifts, or support workers dropping in. As in SILP, the individual has 24 hour access to staff by telephone, at any time staff is not with them.

The three kinds of programs listed above) are run by private agencies, under contract with the Division. All individuals served by these agencies are also served by and receive service payments through the Division (except for a very few individuals who pay privately). Agencies typically operate more than one home or site and several operate more than one program. Each agency has an **administrator** who may be called an Executive Director. The administrator or someone designated by the administrator should be available at all times in real emergencies

Adult Foster Care (AFC) - Adult foster care provides 24 hour care to individuals in private homes. **The provider is the person in charge**, who contracts to provide services. There may also be a **resident manager** and one or more **caregivers.** Typically either the provider or the resident manager lives in the home. Each Adult Foster home is licensed by the Multnomah County Adult Care Home Program, and then various agencies, including the Developmental Disabilities Services Division, arrange for service provision to individuals. Some individual make private pay arrangements for Adult Foster care, not through an agency.

Other kinds of residential supports - Individuals may have various kinds of **respite** (temporary) care, in group homes, in AFC, or with private individuals. Or they may have some paid supports in limited areas like money management. If they are elderly or physically disabled, they may receive foster care, personal care services, or other kinds of services from Senior and Disabled Services Division. If they have mental illness, they may receive help from a mental health agency.

Prepared by Lee Greer, Service Coordinator/BehaviorSpecialist
Multnomah County Developmental Disabilities Services Division
5/00

CHILD AND ADOLESCENT ASSESSMENT AND INTERVENTION

NOTES

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

NOTES

SUICIDE INTERVENTION

Suicide Prevention

- Develop your interview around a knowledge base and your questions will follow.
- Interviewing: The Basic Rule, "Always ask"
- Straightforward...Do you have thoughts of hurting or killing yourself? Ask the S word.

  How would you do it? Specificity.
  When and where would you do it? Specificity.
  Do you have the means to do it? Lethality.
  Why now? What is the final straw?
  Why *not* now? What are the protective factors?
  When and with what in the past? What was their impression of it?
  What level of control do you feel? How are your brakes?

- **Reasons for Suicide:**

#1. Person is in acute distress.
#2. Suicidal individuals are ambivalent: see choice as "life or death". Engage in the "I win" game = If I live I win, if I die I win. Good example is the "Police assisted suicide"...drop the gun or we'll shoot.
#3. Person is cut off from outside support and therefore focus on relationships in the institutional setting.

In hospital studies (John Hopkins/Harvard Medical School) it was found that the symptoms prior to suicide included: Dysphoria (86%), Psychosis (50%), Somatic Anxiety (43%), Psychic Anxiety (93%), Agitation (79%), Lability (93%)

Farberow (1966) studied 218 suicide cases and found the predominant pre-suicide behaviors for the "active group" to be: restlessness, agitation, hyperactivity, pacing and sleep disturbance. For the "passive group" they were: severe depression, isolation, muteness, withdrawal, complaints about health and ambivalence about being in a hospital.

- **Risk Factors**: Sex, sexual orientation, age, alcohol/drug; plan, means (especially firearms), emotional upset, mood disorder, psychosis, physical health, incarceration, support system, recent loss or anniversary of loss, severe anxiety or turmoil, global insomnia, delusions of doom and gloom. Decrease the risk factors and you decrease the risk.
- **Highest Risk**: White, male, recent loss (job, spouse, financial support) alcohol on board. Risk increases with age after fifty. Has a realistic plan and the means to carry it out especially possession or access to a firearm.

- **High Risk**: Incarceration, alcohol or drugs on board, humiliation over arrest/charges (e.g. sex offense, particularly first arrest). Highest risk is during the first few hours of incarceration.

- **The Lethal Triad**: An upset person, with a firearm, with alcohol on board.

- **Important for jail and hospital settings**: Death by hanging is second only to firearms as the means of suicide. Approximately 17.2% of male suicides are by ligature and 14.3% of female suicides. (63.3% and 41.3% for males and females by firearm).

- Stats:
- Females threaten suicide more frequently than males by a factor of 3X.
- Males succeed at suicide more frequently than females by a factor of 3X.
- Incidence of female suicide is relatively stable.
- Rough guess is that there are around 25 attempts for every successful completion. This is an average as among the young there are about 100 attempts per success but among the elderly it may be about 4:1 to as high as 2:1.
- Elderly, white males have the highest incidence of successful suicide.
- 33% of elderly suicides saw their M.D.s the week of the suicide.
- People with a history of abuse as children have a 30 fold increase in risk.
- Oregon ranks 9th in the U.S in suicide rate.
- Suicide is the leading cause of death in people with bi-polar disorder:
  Major depression...20% BUT 98% of suicides are seriously depressed.
  Bi-Polar ... 25% to 50%
  General Population...1%
- In Schizophrenia, 20 to 40% attempt suicide while 10 to 15 % succeed.
- Nationally the rate is 12/100K/year
- This increases to 380/100K/year for people with untreated mental illness.
- Suicide ranks as the 9th leading cause of death in the U.S.
  3rd for fifteen to twenty-four year olds
  14th for elderly
- There has been a 200% increase in suicide rates among Black males.
- Successful suicide rates in the U.S. are: 8:2 male to female....9:1 white to non-white.....7:2 white males to white females.....8:2 non-white males to non-white females
- 2 to 6% of suicides occur in hospital settings (620 to 1800/year or 3/day or 1 per 8hr shift.
- In Oregon, the rate is 12 to 32 per year in hospital settings.
- Nationally, the rate of suicide on Medical/Surgical Units is 42/100K.
- On Psychiatric Units this increases to 90-150/100K. (In Finnish psych units the rate is 400/100K)

- Always take threats seriously even from those you believe are manipulating. Personality disordered individuals have been known to kill themselves just to prove they meant what they said ("I'll show you").

- One in ten with a diagnosis of Borderline Personality Disorder will eventually suicide.

- Look for sudden changes in mood, e.g. a depressed individual who suddenly seems to have "gotten over it". They may have made up their mind to proceed with a suicide.

- Look for **classical symptoms** of depression; ask about: appetite, sleep, energy, sexual drive-interest-performance, concentration, and mood. What you are looking for are **changes**, which may be sudden or have been occurring over the past few weeks.
- Most common: **Anergia**...loss of energy.
  Anhedonia...loss of enjoyment or capacity for pleasure.
  Loss of sexual drive, interest, response.
  Hypophagia...loss of appetite with accompanying weight loss.
  Hyperphagia...excessive eating with accompanying weight gain.
  Insomnia...difficulty falling or staying asleep.
  Hypersomnia...excessive sleeping with no sense of rest.
  Loss of concentration, short attention span.
  Low mood, tearfulness, irritability, hopelessness, and despair.
  Excessive guilt.

- Some people may not acknowledge being depressed but they may endorse many items on the list above.

- Suicidal individuals can hide it from you and carry out a successful suicide. You will be left wondering about what more you should have or could have done.

- **Substance Abuse and Suicide:** Lifetime risk 2 to 3% (Two to three times the national average). 15 to 25% of all suicides are by alcoholics. Intoxication is associated with 50% of all suicides.

- **Sobriety is essential.** Substance abuse increases lifetime risk of suicide by 2-3X. 15 to 20% of all suicides are by alcoholics. The highest risk in this group is a male with a long history of drinking who also has a co-morbid psychiatric disorder. Intoxication is associated with 50% of all suicides. Alcohol produces "alcohol myopia" which is the inability to perceive consequences of behavior.

- **Buffers, the "Wall of Resistance":** A strong religious prohibition against suicide. Clean and sober. Intact support system. Willingness to examine options and make a no-harm contract. For women, the best protector against suicide is a child. The more children, the lower the risk...ask "what will become of your children?". A job, a pet, a counselor or therapist. Duty to others. Medication compliance. Good health. Good friends. Job skills, job security. Safe environment and difficult access to means. At

the top of the list is hope. Anything that provides a glimmer of hope to a suicidal individual may be enough to prevent their suicide.

In the final analysis the final decision rests with the individual. However, most suicidal people do not want to die. They want to find a way to live and ambivalence exists right to the moment of death. Reduce risk factors and enhance protective factors and you reduce the risk of suicide.

Primary source of information comes from materials provided by AFSP, the American Foundation for Suicide Prevention

SUICIDAL BEHAVIOR

- Suicidal Behavior
- Suicide Plan
- History of Past Events
- The Persons Resources
- Recent Loss
- Physical Illness
- Drinking and other Substance Abuse
- Physical Isolation
- Dramatic Changes
- Mental Illness
- Suicide Prevention

Suicidal Behavior[2]

A common myth regarding suicide is that people who commit or attempt to commit suicide are mentally ill. Although people who are suicidal are usually in emotional turmoil and although suicide is often preceded by periods of depression, these conditions do not necessarily indicate mental illness. The mentally ill may attempt and commit suicide, but not all that attempt suicide are mentally ill.

Suicide in the United States is the 10th leading cause of death among adults and the second among adolescents. For every suicide there are 8 to 10 attempts, or about 300,000 attempts annually. Suicide knows no boundaries. It cuts across race, class, age, and sex, though its frequency varies with different groups. It is not an illness or an inherited disease as is sometimes believed but is usually a response to a life crisis that the person sees no other way of alleviating. Though many persons who commit suicide are in a temporary state of acute crisis, some are chronically self-destructive and continually attempt suicide.

Listed below are some of the major signs of suicidal behavior. A suicide can still occur without these signs being present, however. At the same time an officer should not hesitate to consider the person suicidal if on ly on e or two signs are apparent. It is impossible to predict suicide in any absolute sense, but inclusions of these signs and guidelines for officers will remove much of the guesswork associated with suicide assessment.

Suicide Plan

Many persons who attempt or commit suicide do so by design. The plan begins with the idea of suicide; suicidal people do not act on impulse but weigh the factors involved. The plan also involves the method of suicide and its lethality. A plan involving a gun will have more likelihood of being effective that will a plan involving tranquilizers. The availability of the means is also a factor. For example, if the person threatens to use a gun and he is a gun owner, the means is clearly available. The final element of a plan is its specificity — time, place, and circumstances. If a person indicates he will commit suicide within two days at a specific time and place, and he has the lethal means, he is a higher suicide risk than one without a plan. The more specific the plan, the higher the risk.

History of Past Attempts

The majority of people who commit suicide have made previous attempts.

The Person's Resources

The officer should assess two types of resources, internal and external. If the person feels life is worthless and that little hope for improvement exists, he or she is lacking internal resources and should be considered a high risk. Lack of

external resources, such as family or friends; or an inability to communicate with those persons is also an indication of high risk.

Recent Loss
Any recent personal loss or the threat of losing a life partner, parent, status, money, or job increases the person's risk of suicide.

Physical Illness
Having a serious illness, especially on that is terminal, that threatens one's values or status, or that is or likely to dramatically affect one's self image increases the risk of suicide.

Drinking and other Substance Abuse
Alcohol or drug abuse is often a sign of other problems, especially if the abuse is recent, and should be included in a suicide assessment. Also, use of alcohol or drugs often increases the risk of loss of control or an increase in impulsive behavior. Alcohol also increases the lethality of a drug overdose

Physical Isolation
The risk of suicide increases when a person is both physically and emotionally isolated. Isolation can cause people to feel they do not belong to a family or society and can increase feelings of worthlessness and other negative self-images. Even temporary isolation may be an impetus for suicide.

Dramatic Changes
A sudden, dramatic, or unexplainable change in lifestyle or behavior may be a clue to suicide contemplation. Change in one's social network and environment such as relocation or retirement can be very upsetting. Also, unexplained changes in behavior are often a symptom of a larger problem, which may in turn increase the risk of suicide.

Mental Illness
Persons who hear voices directing them to commit suicide are certainly in a high-risk situation. However, the number of persons who fall into this category is quite small. If a person indicates that other people, or voices, are controlling his or her behavior, those signs should not be ignored.

In an attempt to determine the existence of any of these signs, the officer must communicate with the person in a calm, direct, and matter of fact way. Talk about the finality of the act and use the terms "suicide," "death," "kill your self." Talking about suicide does not prompt the person to commit the act. The best way an officer can help the person is to discuss the person's problems, the suicide plan, and realistic alternatives. Communication with the person not only enables the officer to gather information regarding the risk, but it is also helpful for the suicidal person. Often the suicidal person has been lacking communication and the

offer's efforts tell him or her that someone is interested and concerned about finding an alternative solution.

[2] All the preceding information about suicide was copied with permission from: Improving the Police Response to the Mentally Disabled. Police Executive Research Forum, 1986.

Suicide Prevention

Suicidal Clues

- Verbal: "it doesn't matter anymore", "you won't be hearing from me again"
- Situational: hopeless and helpless.
- Behavioral: stripping of possessions or relationships, in appropriate calmness/flatness, past attempts.
- What is the Immediate Problem?
- What has happened in last 24 hours that makes you want to kill yourself?
- Identify the problems/situation.
- Identity the loss.
- Talk about it/ventilate feelings.

Identify Hook

- What is still important to the person?
- What still has value/meaning?
- Keep returning to the hook.

Determine Motivation

- What is objective/goal of suicide action?
- What is person hoping to accomplish?

Develop Non-Lethal Alternative Option

- To diffuse crisis state
- To accomplish objective/goal

Develop Specific Plan of Action

- Be realistic.
- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

Suicide Prevention

Suicidal Clues

- Verbal: "it doesn't matter anymore", "you won't be hearing from me again"
- Situational: hopeless and helpless.
- Behavioral: stripping of possessions or relationships, in appropriate calmness/flatness, past attempts.
- What is the Immediate Problem?
- What has happened in last 24 hours that makes you want to kill yourself?
- Identify the problems/situation.
- Identity the loss.
- Talk about it/ventilate feelings.

Identify Hook

- What is still important to the person?
- What still has value/meaning?
- Keep returning to the hook.

Determine Motivation

- What is objective/goal of suicide action?
- What is person hoping to accomplish?

Develop Non-Lethal Alternative Option

- To diffuse crisis state
- To accomplish objective/goal

Develop Specific Plan of Action

- Be realistic.
- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

Suggested Dialogue

- Look I can see you're really (label emotion) right now. I just want to talk with you for awhile.
- I really care about what happens to you. That's why I have this job.
- I know talking about this is really rough, but we can take it slow.
- I sense you're really down on yourself right now.

- Do you really want to die, or do you want to not hurt so much?

Finality of Death

- Once you're dead, you're not going to get another chance.
- You know if you kill yourself to get back at _____, all that's going to happen is that you'll be dead. We can't be sure of _____'s reaction. _____ may not care at all. Therefore _____ wins. You're dead and _____'s going to go on with their life.
- I guess right now you want to get away from the hurt, but dying (method) is pretty painful. Let's talk about some other way to get this pain out of your life.

Hooks

Parents

- How do you think your mother and / or father will deal with you killing yourself?

Children

- How do you think it will affect (name/'s) if you kill yourself?
- You know, if you kill yourself, you'll never see _____ grow up, graduate, get married. I can tell you care about them a lot.

Job, Career, Hobby

- You know, you've told me that you've made some pretty important breakthroughs in your job, if you killed yourself, you'll never have that satisfaction again.
- You were telling me about your (hobby), you're pretty proud of _____. What will happen to _____ if you die, will they just get tossed in the trash?

Pets

- What about _____? Who will take care of _____? I guess _____ will have to be destroyed.

Explore Plans / Thoughts

- What do you want to have happen? What would need to happen for you to feel better, feel like you could go on?
- What do you think (you/we) could do to make things not hurt so much?

PRACTICUM

Section 5: Other

COMMON ACRONYMS

(AMHSA) ADULT MENTAL HEALTH AND SUBSTANCE ABUSE
(AFS) ADULT AND FAMILY SERVICES
(ARC) ASSOCIATION OF RETARDED CITIZENS
(ADHD) ATTENTION DEFICIT HYPERACTIVITY DISORDER
(ADD) ATTENTION DEFICIT DISORDER
(BHD) BEHAVIORAL HEALTH DIVISION
(CMI) CHRONICALLY MENTALLY ILL
(CAMHSA) CHILD & ADOLESCENT MENTAL HEALTH AND SUBSTANCE ABUSE
(CCMH) CLACKAMAS COUNTY MENTAL HEALTH
(CIT) CRISIS INTERVENTION TEAM
(CRT) CRISIS RESPONSE TEAM
(CTC) CRISIS TRIAGE CENTER
(DCFS) DEPARTMENT OF COMMUNITY AND FAMILY SERVICES
(DSM4) DIAGNOSTIC AND STATISTICAL MANUAL
(DSO) DISABILITY SERVICES OFFICE
(EAP) EMPLOYEE ASSISTANCE PROGRAM
(ISP) INDIVIDUAL SERVICE PLAN
(MRDD) MENTALLY RETARDED DEVELOPMENTAL DISABILITY
(MHRC) METROPOLITAN HUMAN RIGHTS COMMISSION
(NAMI) NATIONAL ALLIANCE FOR THE MENTALLY ILL
(OAC) OREGON ADVOCACY CENTER
(PSRB) PSYCHIATRIC SECURITY REVIEW BOARD
(SDSD) SENIOR DISABLED SERVICES DIVISION
(SCF) SERVICES TO CHILDREN AND FAMILIES
(SSDI) SOCIAL SECURITY DISABILTIY
(SSI) SUPPLEMENTAL SECURITY DISABILITY

Notes

NOTES

NOTES

NOTES